Music Therapy Research and the Mental Health—Well-Being Continuum

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Abstract
Research interests in the spectrum of mental illness through to well-being are explored across a 30-year trajectory. Case studies are shown to be fertile breeding grounds for more extensive research studies comprising quantitative, qualitative and mixed methods research designs. As services for those with severe mental illness have moved into the community, changes in philosophy of treatment and therapy have been required and these are explained. As mental illness affects 20% of Australians, this area of music therapy practice remains of principal concern. In addition, the search for healing and enhanced meaning of life requires psychotherapeutic practices that allow for changes in intrapersonal and interpersonal growth, and receptive music therapy methods, specifically the Bonny Method of Guided Imagery and Music, is shown to be one of the effective music psychotherapies.

Keywords: severe mental illness, wellbeing, song writing, quality of life, Bonny Method of Guided Imagery and Music

Background
According to the Federal Government, nearly one in five (or more than three million Australians) are affected by a mental illness in any one year (The National Action Plan on Mental Health, 2006), and severe mental illnesses, including bipolar disorder, depression and schizophrenia, affect around two and a half per cent of the population at any one time. At the other end of the mental illness spectrum is “mental health” which is defined as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (World Health Organisation, 2009). My interest in music therapy research is to embrace the diversity of needs across the mental health—well-being continuum.

Mental Illness

My earliest study of music therapy and psychiatry looked at preserved music performance skills in two cases studies – a man with schizophrenia,
and a man with bipolar disorder (Erdenmez, 1979; 1980). The case study design traced pianistic skill relative to treatment and fluctuation in mood. The patient with schizophrenia was studied to record changes in his jazz piano playing relative to electro-convulsive treatment (ECT) treatment. On the day that he had received ECT, his memory was impaired and his playing was very slow and laboured. On days he did not receive ECT the playing was more fluid. However recordings indicated that even when slow and laboured, the patient cued his memory by trying different sequences of chords, until he re-engaged with playing.

The case study of bipolar disorder indicated that piano playing altered alongside psychiatric symptoms. When in a manic phase, the patient’s playing was fragmented. He would start to play one piece but through loose association of musical ideas he would break off and start to play a different piece of different composer, although there was a central musical idea that bridged the pieces. These case studies were an early attempt to look at the connection between music response and brain function, an area that is still of interest (Erdenmez, 1991, 1993).

Following the move to de-institutionalisation and the de-commissioning of the large psychiatric hospitals, the care of people with mental illness moved to community-based programs. For a decade there was little or no research in psychiatry, as many of the music therapy positions had vanished along with the psychiatric hospitals. However a resurgence of interest has blossomed in the past five years.

Recent Research Studies

A Pilot Study of Group Music Therapy and Severe Mental Illness (community-based)

A recent research study in collaboration with the St Vincent’s Hospital Mental Health Unit (Grocke, Bloch and Castle, 2008; 2009) addressed the needs of patients with severe and enduring mental illness (SEMI), who were resident in the community. In a controlled study, we measured social anxiety, quality of life, and symptom status in five groups of patients (N=27) before and after the music therapy intervention. The study provided weekly group song writing sessions over eight weeks as the predominant music therapy method, although singing familiar and preferred songs was used as a warm-up to each song writing session. The registered music therapist (RMT) on this study was Lucy Richards, and she worked with all five groups. The original songs were subsequently recorded in a professional studio, and participants were provided with a CD of their group’s song/s. Measures of quality of life showed a statistically significant positive change on six items (n=17), however there were no significant changes to social anxiety and symptom status. Focus group interviews and analysis of song lyrics indicated that

Volume 20, special issue, 2009  Australian Journal of Music Therapy  7
group song-writing was enjoyable and the group members were surprised by their own creativity. The songs indicated 1) a concern for the world (e.g., “We need to find another way” [to solve the world’s problems] and “build a better world”), 2) relationships, and 3) the challenge of living with a mental illness. We were particularly aware of the theme of spirituality that emerged from the song lyrics, such as: “Breathing, praying and chanting are like giving, living and being in the present.” And “the soul is free and cannot be stolen: the voice, like a bird, sings in the ray of light.” One of the songs focussed on the healing properties of nature “the beauty of nature is healing, being in touch with the rhythm of the seasons, each other and the spirit, helps to be in the flow of the present, to “feel the day, and the sun shall shine forever more.” The sheer creativity and uplifting spirit of these words were positively surprising to us.

Other lyrics represented how difficult it is to live with mental illness, such as: “every day is a struggle, being homeless, scared and confused, feeling broken and shaken,” and “life is a test.” Lyrics also focussed on what qualities are needed to live with mental illness: “you have to be strong to survive, to keep control, and carry the burden.” You also “stand alone.” (You have to) try to “keep smiling and laughing, like the burning sun.” Enthused by the results of this pilot study, we developed a larger study.

A Randomised Controlled Study of Group Music Therapy and Severe Mental Illness (community-based)

The randomised controlled trial, funded by the Australian Research Council, is a replication of the pilot study with a larger sample. The specific hypothesis to be tested is that participation in Group Music Therapy (GMT) will lead to significant improvements in quality of life (QoL). Secondary measures will capture data on self-esteem and spirituality, as this feature was evident in the song lyrics of the pilot study. We will also measure psychotic symptoms to control for the effects of changes in symptom status.

The sample for this project is 160 participants with SEMI who reside in the community in supervised care, or with their families. Participants will be randomly assigned to one of two groups – group 1 will receive group music therapy immediately after randomisation, and group 2 will receive group music therapy after a 3-month waiting period. The intervention is a weekly GMT session lasting 1 hour, over a 12-week period, conducted by RMTs who will be trained to provide consistency in the GMT interventions. The GMT intervention comprises 1) singing familiar songs (warm-up), 2) song writing (composing) original songs, and 3) instrumental improvisation to enhance the group’s song/s. In week 11 the groups record the song in a professional studio, and copies of the song/s will be presented to participants in week 12.
Quality of life, self esteem, spirituality and symptom status will be measured at three points: pre and post intervention and at a 3-month follow-up after baseline. The measures include the Brief Symptom Inventory (BSI-Derogatis, 1975) the Q-LESS-Q Quality of Life measure Endicott, (2000), the Rosenberg Self Esteem scale (Rosenberg, 1989), and the Facit Spirituality scale (Peterman et al., 2002). Focus group interviews for the experimental groups will gather data on the experience of the GMT intervention. Analysis of song lyrics will collect data on the themes being expressed by the groups in their original songs.

The RCT will be the largest study of music therapy for people with severe and enduring mental illness living in the community, and will set a benchmark for future research. The study has begun, participants have been recruited, and data collection will continue until the end of 2010.

A Study of Resource-Oriented Music Therapy (hospital-based)

A second randomised controlled trial is underway in Melbourne at the Sunshine Hospital, Adult Mental Health Rehabilitation Unit (AMHR), for people with severe and enduring mental illness, who are unable to live in the community due to the severity of their illness. The Sunshine AMHR unit provides care for patients for long periods of time, and is one of the few facilities available for very vulnerable patients who require lengthy close supervision. The study is conducted in collaboration with the University of Bergen, Norway, and adopts a resource-oriented intervention. Resource-oriented music therapy is "oriented towards the client's resources, strengths and potentials, rather than primarily on problems and conflicts, and emphasizes collaboration and equal relationships" (Rolvsjord, Gold, & Stige, 2005). The objectives of this study are to determine whether resource-oriented music therapy (R-OMT): 1) helps psychiatric patients who have a low motivation for therapy but a willingness to work with music to reduce their level of negative symptoms (primary outcome); 2) helps secondary outcomes in: (a) general symptoms; general functioning; clinical global impressions, and (b) mechanisms of the therapy: interest in music; motivation for change; self-efficacy; self-esteem; vitality; affect regulation; relational competence; and social relationships (Gold, Rolvsjord, Aaro, Aarre, Tjemsland, & Stige, 2005).

Those assigned to the music therapy condition receive twice-weekly 45-minute individual sessions with a Registered Music Therapist, over 12 weeks (a total of 24 music therapy sessions). The control condition is standard care over 12 weeks, followed by a series of group music therapy sessions, after data have been collected at week 12. Data is collected at four points – pre-intervention, after four weeks (8 sessions), at 12 weeks, and 6-months after baseline. Negative symptoms (including affective flattening and blunting, poor social interaction and lack of interest) are measured by the
Scale for the Assessment of Negative Symptoms (SANS) (Andreason, 2000). General symptom level is assessed using the Brief Symptom Inventory-18 self-report scale (Derogatis 1975). General functioning is measured using the Global Assessment of Functioning, (Spitzer, Gibbon, & Endicott, 2000). Global clinical impressions are evaluated by a blind assessor (nursing staff member) using the Clinical Global Impressions (CGI) scale (Guy, 2000). Self-esteem is measured using the Rosenberg Self-Esteem Scale (Rosenberg, 1989). Finally, in order to measure adherence to the concepts of resource-oriented music therapy, other music therapists assess treatment fidelity on the basis of a randomly assigned video recording. More than 100 patients have already been recruited into this study, from Norway, Austria, and Melbourne. Data collection will conclude at the end of 2009.

**Mental Health and Well-being**

In addition to the standard hospital care and community-based programs for people with mental illness, my research has also addressed music therapy in mental health and well-being. Clients who seek music therapy for well-being/personal growth generally do not have diagnosable disorders; they are often bereaved, depressed (but not on medication), recovering from illness or surgery, or living in unhappy, and sometimes abusive relationships. My practice of receptive music therapy has led me to believe that focused listening to music can be profoundly calming, soothing and healing (Grocke & Wigram, 2007).

One of the specialised areas of receptive music therapy is the Bonny Method of Guided Imagery and Music (BMGIM). The Music and Imagery Association of Australia (MIAA) defines BMGIM as:

“a process of music-centered psychotherapy in which music experiences are used to bring about therapeutic change. This therapeutic process, using the Bonny Method of Guided Imagery and Music (GIM), involves the client listening to specifically programmed classical music in a deeply relaxed state. The client may experience visual imagery, feeling states and/or body responses as evoked by the music. The therapist engages the client in a dialogue to enhance the experience of the imagery. This process facilitates the client to explore and to resolve major life issues in a supportive manner” (MIAA, 2009).

BMGIM is best suited to clients who are able to enter into, and return from, an altered state of consciousness, and who can gain insight from the experiences they have. For this reason the method is not well-suited to people with severe mental illness, particularly people who have psychotic illness. However Short (2003), has demonstrated BMGIM as effective in the rehabilitation of patients post cardiac surgery.

Clients have diverse experiences during BMGIM sessions, involving all of the senses, not only visual imagery (Grocke, 2005). Other common
experiences are memories (of childhood and also recent events), embodied responses (feelings within specific parts of the body), and somatic experiences of internal organs (e.g. the heart opening out). Clients may experience the music in unusual ways, such as feeling that the music is being played especially for them, or there may be direct transference to the music as if the music is giving the person a message. Spiritual experiences are common in BMGIM, such as being drawn toward a light, or a spiritual person appears in the form of a monk, priest, or woman in flowing robes (usually bearing a message of importance). During these spiritual moments the client may feel transformed in some way. Archetypal figures (sometimes from legendary stories) may appear such as King Arthur, Robin Hood, the Vikings, an Aboriginal man/woman, the witch, Merlin, and more recently Harry Potter (and his Invisibility Cloak), and Dumbledore. In addition, symbolic shapes and images that hold significant meaning may appear, such as a long tunnel, or seeds opening that can be symbolic of moments of change or transition. Symbolic images such as an ancient book or writings often have specific meaning to the client (Grocke, 2005).

But perhaps the most effective component of BMGIM is the opportunity for the client to dialogue (in an altered state of consciousness) with a significant figure. This is particularly effective in grief resolution if the client has been bereaved, or has multiple griefs, or disenfranchised grief. Typically a client may need four to six sessions to understand the process involved in BMGIM, but once able to engage with the music and the imagery (facilitated by non-directive interventions of the therapist), clients may achieve significant shifts in their interpersonal and intrapersonal relationships. Some sessions stand out as more significant than others, and these have been termed by the author as “pivotal” moments (Grocke, 1999).

Pivotal Moments in BMGIM

My doctoral research investigated pivotal moments in BMGIM by asking clients to retrospectively identify a session that stood out as being pivotal (Grocke, 1999). Seven participants (three male; four female) gave informed consent to be interviewed and to have the interview recorded. The seven interviews were transcribed and were analysed using a phenomenological distilling process (Forinash & Grocke, 2005), including verification by the participants themselves that the analysis was accurate. Global themes were then distilled, and five common themes emerged across the participants’ experience:

1) Pivotal moments were remembered and described in vivid detail. All participants gave very detailed descriptions as if the experience was indelibly inscribed in their memory. For one participant the pivotal session had occurred three years prior to the interview, yet the image remained as vivid in the interview as in the session.
2) Pivotal moments were emotional experiences. The seven participants described a) a sense of coming home, and that something lost had been found, b) loss and sadness, b) feelings of beauty and being uplifted, c) feelings of anguish, negativity and discomfort, that were then transformed, d) feelings of fear replaced by a feeling of love and acceptance, and e) freedom in letting go.

3) The pivotal experience was embodied. These body sensations included hollowness in the abdomen, replaced by warm breath filling every part of the body, shivers down the spine, and music pulling at the heart, the body shaking at the recall of a fire and body tingling, the body expanding and being able to breathe without restriction, a choking sensation in the throat, and sadness deep inside.

4) The pivotal experience impacted on the person’s life. All seven participants described how the pivotal experience had impacted on their life: a) changes to the physical body, standing differently, feeling taller, b) that change had shifted permanently; c) strength and courage applied when something needed to be sorted out, d) being able to start building life, and recurring bad dreams reduced in intensity, f) ability to take control and make decisions; g) greater confidence, h) changes for the better in relationship to others and within oneself, and i) improved communication.

5) The pivotal experience emerged from unpleasant feelings or images that were uncomfortable, unpleasant or horrible. This theme was a surprising outcome of the study, and these challenging experiences were described as follows:

David felt loss, sadness and frustration, and at that point his abdomen felt hollow, empty and vacuous. Out of this feeling came the image of himself as a 3-year old boy, and warm breath filled his body.

Pamela re-lived a childhood trauma of fire destroying the family home that was expressed as a dreadful experience. In re-living the experience Pamela explored her grief, sadness and fear.

Suzanne’s experience was initially negative, as she chiselled away at a rock representing the negative images of God. As the rock changed to lava and started to flow, a gold nugget appeared, symbolic of positive change. A sense of freedom replaced the feeling of frustration.

Bernadette experienced a choking feeling in her throat that she said was a strange sensation. As her throat began to make a feeble sound, the experience changed to the positive. There was a sense of freedom as her voice got stronger and she accepted the role of the lead singer in her imagery. The overall experience was wonderful and powerful.

Timothy’s experience was of an image of a dead baby on a barge. The image was deep within him, and there was a sense that it was unresolved. The appearance of a live baby alongside the dead baby went some way to resolving the image for Timothy.
The emergent theme for these six of the seven participants was that the pivotal moment occurred following an imagery experience described as “horrid” “awful” or “hateful.” In the process of confronting this awful experience, participants drew on inner strengths, that enabled them to resolve the issue such that, as Suzanne stated “I left that session feeling at last I can move on.”

The strength of the music in supporting clients through these moments of confrontation is crucial in BMGIM. Participants found it difficult to talk about the music, as it is a temporal experience, and describing it requires some familiarity with music language. The music that underpinned the pivotal experiences was mostly from the German tradition: Brahms, Bach, Richard Strauss and Beethoven (Erondnez Grocke, 1999, 2007) and the archetypal structures of form, style, relationship of key, melodic contour, rhythmic features, repetition and predictability combined to provide solid support within which participants could address frightening imagery experiences, and move through to resolution.

Oliver Sacks (2007) has stated that music “is both completely abstract and profoundly emotional . . .and has a unique power to express inner states of feelings” (pp. 300–301). There is also a paradox says Sacks “for while music makes one experience pain and grief more intensely, it brings solace and consolation at the same time” (p. 301). This paradox was borne out in the participants’ experience.

Research in BMGIM and other forms of music psychotherapy is under-represented in Australia; currently there are very few music therapists working in a music psychotherapy model with clients who are seeking better mental health and well-being. My research vision for the future therefore is to pursue greater investigation into music psychotherapies, including the diverse receptive music therapy approaches (Grocke & Wigram, 2007).

**Conclusion**

In the process of reflecting on my research past, present and future, I am aware that case studies have been the starting place of my research in both mental illness, and mental health/well-being, and from those case studies, quantitative research (in mental illness) and qualitative research (in mental health/well-being) have allowed more intense research into areas of interest found in the original case-work. This suggests that case studies are pivotal as breeding grounds for research ideas, and that through grounded case study research designs, more elaborate research protocols develop. In addition there is a natural development in skill and focus over a sustained period of time from the clinical perspective and evidenced-based practice, to the refinement of a research design and protocol.
References


