Music Therapy as an Exercise in Humanity

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Abstract
The pursuit of "hard evidence" without consideration of theory or practice unnecessarily constrains the creation of useful evidence. Gold's pyramid of the theory, practice and evidence provides three lenses through which the clinician can become reflexive and progress to pertinent research. The author's journey through reflexive practice and research is illustrated through her work in neonatal music therapy.

Keywords: music therapy, reflexive, neonatal, sociology of medicine

A year into my PhD I had a chance meeting with a colleague who asked me why I was on campus at Melbourne University. When I explained that I'd started my PhD, she commented that it made sense as I had been "doing research" for years. While I understood what she meant, I hadn't thought of myself as a researcher, but rather a clinician who presented and wrote about my work. Over the years I pondered the disparity in our conceptualization and the answer has come slowly as various experiences caused me to reflect on the experience again. One part of the puzzle was put into place recently in my work as a supervisor, when my final year student struggled to answer some questions I put to her about her understanding and professional beliefs of her clinical work. In discussion she explained that no-one had ever asked her such questions, and therefore she struggled to formulate a reply. I realized that across my years as a music therapist I've answered all sorts of questions, from the inane to the superbly challenging, and as a supervisor I've become accustomed to asking questions of many people, including myself. I have always disliked the sensation of not being able to answer a question, even if it is my own question. I expect that if I've asked that question, perhaps someone else will too. My constant searching is really just a process to answer questions.

At the time of writing I have been a music therapist for 28 years; I've been involved in research for 10 of those years. These two professional paths provide the focus for this paper illustrated through my own journey into research in neonatology. Firstly, I will address the idea of being a reflexive practitioner, asking questions and searching for answers. Secondly, how these questions and the search for answers leads to research.
The Foundation for Evidence

Last year I attended an international research conference at which I met a fascinating group of women from Ireland, Saudi Arabia, and Australia, all involved in health care, but from several professional backgrounds. After each of many papers, Jean Clark, a public health nurse from Ireland, reiterated the same question, “Where’s the humanity? Why aren’t we talking about the humanity?” Over several days together, our comments and small conversations grew into several pivotal ideas. Of them, the humanity of care remained key for me. I understand the idea of humanity of care to potentially mean human interaction with a mutual understanding, or a partnership in which basic concern and respect are featured, and service to another person in which dignity is fundamental. Jean shared stories of her work (as a public health nurse and researcher) in a hospital in Ethiopia, a starkly barren healthcare system which exemplifies the oppression of the Ethiopian people generally (Van der Geest & Finkler, 2004). She engendered such rich verisimilitude that we all shed tears in sharing her stories. We debated the sophistication of Western healthcare in our own nations, the counter-balancing cost of scientific technical capability and the loss of understanding about the intimate simplicity of the human experience.

On my return to The Royal Children’s Hospital, Melbourne, I found myself compelled to relay Jean’s stories to the music therapy team, and afterwards, the words tumbled out of my mouth, “There is no doubt that music therapy is a luxury, that we live in a privileged society, where we aim for world best-practice, but sometimes don’t achieve the simple humanity of care.” The question that nagged at me was “Why not?” How is it that the development of science in medicine has not been paralleled by a development in the sociology of medicine? When did the humanity of care cease to be important?

We are fortunate that there is an emerging consideration for the sociological aspects of health care, exemplified by new models such as family-centred care in paediatrics and developmental care in neonatology. While the juggernaut of objective evidence creation continues relentlessly across the landscape of public health and education research, there is also a burgeoning and steadfast collective of social science researchers who are clear and purposeful in the development of rigorous processes to celebrate humanity in all its messiness and intimacy. The privileged voice of science is reluctantly engaging with the open-ended processes of discovery alongside the more familiar pathways of empirical testing.

The word “evidence” is an umbrella term which is largely accepted to mean proof of the effect of a treatment. The development of evidence-based biomedicine privileges that linear knowledge gained by the anonymous large

1 Jean Clark has given her permission for me to tell this story.
“N” sample in a RCT study however it does not serve the individual in treatment. So at its simplest level, this linear model means a medical condition plus a treating drug equals an outcome. Writing as both an anthropologist and a mother in the neonatal intensive care environment, Linda Layne (1996) noted that “faith in progress has resulted in a “stunted symbolic vocabulary” (Newman, 1988, p. 9) for discussing anything that does not conform to our expectation for linear progress.” Layne’s experience of the NICU was not a simplistic linear concept, but a messy circuitous path through progress and set-backs, hope and devastation. Her report of this individual “critical case” (Flyvbjerg, 2006, p. 229) provides a strategic reminder that “best care” models must be a multi-faceted schema which embraces multiple knowledge bases. At the very least, the essential domain of science must be accompanied by sociology. A research agenda therefore must build a solid foundation for the more ambitiously complex agenda of the “humanity of care”.

As experienced researchers, O’Callaghan and Munro (2008) surely have pre-conceived ideas about how those in a cancer centre value the experience of music. However in their latest research endeavours, rather than constraining their inquiry by their own criteria, they asked open-ended questions through which participants offer what they feel is important to them. This dismantles the researchers’ privileged epistemologies, allowing the participants’ voices to be as potent as the researchers’ in creating a fuller compliment of views in the multi-faceted experience of cancer care. Such research exemplifies the humanity of care.

We are fortunate to be working in an era when the bases for music therapy are better understood, the work itself is more developed, and the methodologies for research are developing rapidly. Could it be that the simplicity of musical interplay might serve as an exemplar case (Flyvbjerg, 2006) for humanity of care? Music therapy is highly congruent with two well respected and emerging models of acute healthcare - care family-centred care (Shoemark & Dearn, 2008) and developmental care in neonatology (Hanson-Abromeit, 2003). That congruence deserves further exploration.

Like other music therapy authors, I believe that music therapy is an intimate interpersonal process (Abrams, Dassler, Lee, Loewy, Silverman, & Telsey, 2000; Ansdell, 1995). Quite literally, it involves one human being sharing music with another human being. The humanity of the shared experience may be overlaid with levels of complexity, but at its bare level, it is a moment of shared humanity.

I am excited about how we explain, illuminate and research the intimate human connection in music therapy and yet at times, I am also overwhelmed by the enormity of what is to be achieved in music therapy

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2 My intention is to provide companion knowledge to those who will continue to dismantle the process of therapy to provide good evidence for effect and efficacy.
research. I comfort myself with diagrams to organize and clarify the relationship of the various domains and levels of knowledge and evidence. Thankfully, others share this predilection. Christian Gold has suggested an elegantly simple tri-level pyramid for music therapy research in which theory serves as the sound base for the middle level of practice and above that at the peak is the search for validation or evidence (Gold, 2008). The diagrammatic declaration of this traditional formation renews a vital relationship which is sometimes lost in clinical practice. While we have been well-served by writings which describe the method and rationale of what we do, I am thrilled by the stellar minds now reconnecting us with the fundamental underpinnings of theory (Daveson, O’Callaghan, & Grocke, 2008; Edwards, 1999; O’Callaghan, 2005 to name Australian authors leading the way). The continuing development of epistemology (systems of knowledge) causes a vibrancy in the theoretical frameworks which we may all use to re-examine what we feel we already know. In parallel, the recent development of new research methodologies enable us to do so much more than describe our methods and rationales, and finally developments in both of these levels means that this is the time to hold our nerve, and be poised for an era where music therapy research may come into its own.

Complimenting Gold’s pyramid (2008), Kenny (2003) suggested that theory might offer us a map which traverses the territory of our clinical practice. The map serves as a scaffolding that connects various aspects of practice together. In this analogy, the evidence is a brief stop to take a snapshot of what is occurring at that time.

The adjustment from clinician to researcher can seem massive, but indeed there are many resting points along the way which could also serve as places to pause and do a little of both. How can a clinician on a limited contract “do research”? How does a clinician develop a rigorous approach when time does not permit, or there is no-one with whom to share the ideas? In the remainder of this article I would like to use the research pyramid to share some ideas about how that might be achieved.

**Reflection and Reflexivity**

The pyramid (Gold, 2008) provides three types of lenses - theory, practice and evidence - through which an accurate picture of music therapy may be built. I would add a fourth lens - the self. As unique individuals, we influence the interpersonal process each and every time we engage with clients. As unique individuals we also influence the ways in which we understand that engagement. By consciously using that combination of unique lenses we actively create a depth of insight that will help us progress our practice, research and writing. While we might gravitate to one lens or another, the task of reflexivity is to begin with the self, and add at least one
other lens. Such a process enables us to construct a picture which is pertinent to our self as a music therapist in the context of our work.

Some authors make a useful distinction between reflection and reflexivity (Finlay & Gough, 2003). As clinicians we all think about, or reflect on the progress of a session, seeking to understand the interplay between participants, the impact of decisions made and responses given. To become reflexive, the clinician may first locate him/herself as the central character, understanding what it is that s/he believes and knows, and then measures his/her interpretation of the experience against that. At the 2005 Infant Mental Health World Congress, psychotherapists Mechtild Papousek and Nicole Guedeney presented two distinct therapeutic approaches to a clinical case of intergenerational psychopathology. We were privileged to watch video footage of mother and toddler struggling to be together. Both psychotherapists were eloquent in their interpretations and considerations for treatment from different theoretical standpoints. When the moderator thanked Nicole Guedeney for constructing an approach to treatment which was not commensurate with her own, I was struck that she had filtered the text-based and audio-visual material she’d been able to stand aside her personal beliefs and preferred systems of knowledge to reflect on the experience through the other lenses.

To stand back and understand an experience through one or another lens, the clinician and researcher must first understand what he/she implicitly brings to the table. Once we move beyond our generic entry level knowledge as a new graduate, we build a range of experiences which will test, confirm, or fail to resonate with our own beliefs. In further reading, sharing and supervision, we learn to unpack the interfaces between self, knowledge and skill. We can begin to honestly review the impact of our implicit interpretations on the session. This is how I explain reflexive practice. For instance, as a neonatal music therapist, my belief that music therapy is an interpersonal process of interplay gives priority to the medically fragile newborn infant’s psycho-social status and responses rather than his/her physiological responses to music. I know that I believe that the infant as baby is distinct from infant as patient with the collection of medical problems. While the range of experience during hospitalization will impact on the baby, I believe that musicality is a fundamental part of the self which seeks to be connected with people and potentially remains intact despite medical problems. Thus, we can come together in that musicality or pre-music and share the exquisite human potential for making music together.

To illustrate the potential application of the four lenses – self, theory, practice and evidence - I will elaborate on my agenda for neonatal music therapy research as I currently see it.
Self

When we speak, write or do, our voice, words and actions speak the knowledge we have, and with or without our awareness, they speak of the culture and personal heritage through which we’ve matured. This foundation enables us to share with others, find understanding, and collaborate to construct a premise and rationale for the evidence we wish to produce.

My “voice” still resounds my Australian up-bringing as a doctor’s daughter who attended a private school and lived in a middle class suburb of a regional city. My cultural heritage was enriched by living in another country for two years, and by marrying a man who had grown up in different circumstances from me. Apart from motherhood, my singular career as a music therapist has focused my development of knowledge and skill across 28 years.

I understand that experienced clinicians work differently from novice clinicians (Shephard, 1999) and achieve different outcomes (Kain, 2004; Okiishi, Lambert, Nielson, & Ogles, 2003). I personally understand this from my work in supervising students and entry level professionals. Standing back from the work itself, and considering how the experienced clinician thinks about the work, I agree with Barker, Pistrang, and Elliott (1994) who noted that significant findings by “accident” may occur when a researcher has sufficient experience and knowledge to appreciate its significance. If you have worked across the map of your own practice (Kenny, 2003) enough times and in enough variations, you are able to see subtle changes, possibilities and pitfalls.

After many years working with children with sensory impairments, I accept that communication is the central attainment by which we gauge child development (Aldridge, Gustroff, & Neugebauer, 1995). The impact of this is that while I have worked through many programs to develop motor and other skills, without communication, these other aspects of a program will falter. Further however, and significantly in the work I currently do with infants and families, I believe that relationships are the fundament of all interpersonal work. This impacts directly on the further lenses of theory, practice and evidence. Each and all of these aspects of my beliefs and understanding contribute facets to the personal lens through which I filter what I see, read, hear, discuss, consider, and decide.

Theory

In neonatal music therapy, the early premise (still being explored) was that music impacts directly on the physiological self. Studies feature music to maintain or safely challenge homeostasis. The studies on recorded music focus on the effect of music directly on the physiology of the infant and thus potentially the clinical pathway (Butt & Kisilevsky, 2000; Caine, 1991;

If we accept Trevarthen’s theory of innate intersubjectivity (Trevarthen 1998), then we are all inherently social being with a need for companionship (Trevarthen, 2001), and we must also consider that this potential is predestined in the embryonic structuring of the brain (Panksepp, 1998). Therefore by the time the music therapy clinician comes onto the scene, the infant has pre-determined motives and capabilities for attending and responding to a range of auditory experiences. As music therapists, we are fond of saying that no previous music experience is needed to successfully participate in music therapy, however we constantly make use of clients’ musical heritage by employing their preferences and implicit musicality. Why not the infant’s? The premature infant does bring experiences since birth, and the full-term infant brings the memory of prenatal experiences (Hepper, 1995; Hepper, Scott, & Shahidullah, 1993; Parnscutt, 2009).

So with the infant’s musical history and preferences in play, and with the belief that relationships are at the core of development, the theoretical basis for my interest is not in the physiological impact of music nor primarily in the potential of music to impact on state. It is in the potential actuation of the infant as a social being, and the inherent musicality of that presence as a meeting point for promoting well-being and development. Is there evidence for this? The documented music therapy practice is emerging (Shoemark, 2006, 2008; Stewart, 2002). In this instance, theory must serve as the basis for practice and research and guides our way forward.

**Practice**

As clinicians, our accumulated experience of implementing music therapy builds our capacity to generalize that experience for other clients. Through reflexive practice we develop language which gives voice to the originality and innovation in that practice. My own previous experience as a
music therapist working with children with profound multiple disabilities favoured song form to support highly structured and supported improvisation. Music deconstructed from its stylistic amalgam liberated the primary elements of register, timbre, melody, pulse, tempo, silence and offered up the potential for modest reconstruction into simple phrasing (Shoemark, 1992). On transferring to neonatology therefore, that strong appreciation for the potency of deconstructed music formed the cornerstone for musical interplay. While newborn infants do not offer spontaneous music-making, their vocal, gestural and facial expressions can be interpreted by inherent musicality and thus form the infant's active role in the music-making.

In response, as therapist I construct melodic motifs which serve to entice, respond and direct the interplay (Shoemark, 2008). The transition between musicality and music dances from highly-intonated speech, through semi-sung motifs, single sung lines and finally into song (Shoemark, 2008).

The language I use to articulate these methods began in reflexive clinical practice and was explored and refined through research. Apart from the benefit to my own clients, I intended that this conceptual framework might serve other clinicians to develop their work with their clients and serve researchers who may refine and test the concepts discovered.

Evidence

Research cannot be undertaken by just anyone walking in off the street because of the complicated mechanisms of privilege which have evolved over time. At the outset of research, applications for funding and ethical clearance are prepared in the sophisticated constructs of expertise of the prevailing culture, and thus approvals are offered on the basis of that culture's concepts of proof, truth and fact. The singular mechanism for research to become evidence is for it to be scrutinized by a panel for presentation and publication. While this further exclusive dimension ensures standards it also privileges strands of knowledge and thus defines the accepted parameters for research. In creating evidence for music therapy, we must be mindful of this research "machine", but must also understand that we still have choices as to which aspects of the machine we dedicate our efforts.

Working from our theoretical and practical basis (in which we have ourselves privileged certain knowledge over others), we can develop our own strands of emphasis through the partnerships we develop for research. When I participated in the Music therapy for vulnerable infants study with Stephen Malloch, we began with the broad idea of examining how music therapy in the NICU (practice) might reflect communicative musicality (theory). With a two page summary to entice, we sought partnerships with like-minded, skilled people to form the research team. We assembled our diverse expertise and only then determined the specific parameters of the project. With my
emphasis on relationships, I see that partnerships enable us to develop projects beyond our own individual capability.

Beginning in partnership with another person, each project might develop a variety of evidence. In neonatal music therapy, I can develop different strands of knowledge (again a level of privilege) by cultivating partnerships with different professions. I might couple with the neurologist to investigate the impact of recorded music on an aspect of physical well-being (sleep, pain tolerance), with the neuropsychologist and psychologist I might work on developmental issues (thresholds for stimulation, behavioural manifestations of musicality, impact of recorded music on infant state), and with the infant mental health worker and parent, it might be relational projects (value of singing for mothers in NICU, value of partnering with mother to sing with infant). Strategically, I will choose some people to serve as gate-keepers to promote the passage of the project through funding, ethics, and publication, I will choose others to serve as collaborators in design, implementation, and write-up, and others still as partners to stimulate and clarify the ideas which I most value. While I welcome and value the strands of knowledge being developed through RCTs (Arnon et al., 2006; Cevasco 2008; de l’Etoile, 2006; Whipple, 2005) I am much more likely to pursue a research agenda which develops the potential of discovery music for critically ill infants through discovery. Therefore, I am attentive in my pursuit of those partnerships with like-minded partners who will share in a project from which they might develop the other dimensions of evidence they privilege.

In this manner, the potential lack of funding by the major machinery of the NH&MRC and the ARC, may also be ameliorated. Clever partnerships will champion the need for research which acknowledges the humanity of healthcare.

The Humanity of Research

The potential of music therapy research to meet a growing interest in the experience of care means that we could be well placed to not only participate in multi-faceted research but also acknowledge the humanity of care as pivotal in modern medicine.

Gold’s pyramid (2008) offers us a model through which reflexive practice can be promoted. Through the addition of the self as the first lens to accompany theory, practice and evidence, we can make authentic decisions about the evidence we wish to create, while sustaining the humanity of our work in music therapy.
References


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