Empowerment: An intrinsic process and consequence of music therapy practice

Barbara A. Davison B.Mus (Music Therapy), RMT
Senior Music Therapist, Eastern Palliative Care

Abstract

In this article empowerment is explored with reference to music therapy practice. The idea that empowerment is intrinsic to and a consequence of music therapy practice is suggested. Exploration of literature and clinical vignettes highlights the ways in which registered music therapists (RMTs) use methods that are empowering, and provide insight into the ways in which RMTs can conceptualize their practice as empowerment. Through the analysis of this material, action dimensions that form part of our practice, that are empowering, and that may lead to empowerment are highlighted. The vignettes and clinical references contained in this article are derived from numerous fields including pediatrics, special education, disability and palliative care. The ideas presented in this article are related to all fields and frameworks of music therapy practice.

Empowerment

Empowerment has consistently been described as a process, or mechanism, that results in people, organisations and communities gaining control over their own lives or situations (Brown, 1991; Grace, 1991; Rappaport, 1984; Shields, 1991; Vogt & Murrell, 1990). This may take the form of a process achieved through action (Grace, 1991; Kieffer, 1984) or a process that entails the restoration of power and choice so that people may act, or cognitively and emotionally respond, in ways that are authentic or true to themselves (Brown, 1991). Empowerment may therefore not always result in action; it may result in a changing of emotional response to a situation; a cognitive restructuring; a shift in how one appraises an event or interaction; and or a change in the perception of one's opportunities for choice and control.

For some, empowerment will lead to a perceived sense of control while for others, it may lead to actual control resulting in practical power that affects one's life (Rappaport, 1984). This actual or perceived sense of control can be realized in many areas including political, economic, interpersonal, psychological and spiritual domains. Shields (1991) maintained that when empowerment occurs one will move from a state of powerlessness to one of motivation. Empowerment may also result in the acquisition of practical skills and the reconstruction and reorientation of deeply engrained systems of social relations (Keiffer, 1984). Change that results from the empowerment process may therefore be viewed as a spectrum that ranges from minute or discreet, to pervasive and significant. The severity of change is defined by how the empowered person chooses to define it and therefore in ways that are authentic to him/herself. The way an observer or therapist may define or describe the change could therefore differ from the description of the person who has experienced empowerment.

Similarly to Shields (1991), other authors maintain that empowerment arises from a sense of powerlessness (Brown, 1991; Keiffer, 1984). More specifically that it develops from an individual's perception that they are not able to determine outcomes in their life in the way they would like. This would suggest that this process, in part, occurs through a gaining of insight that is enabling. In this respect, empowerment could be conceptualized as a type of process whereby a client or therapist experiences resistance. Resistance may inhibit the person's ability to act in a way that is true to them. In this situation, empowerment does not necessarily have to begin from a sense of powerlessness, however as the process of empowerment occurs, the person may experience a sense of powerlessness before experiencing a sense of powerfulness. In this scenario the client may be able
only to identify these feelings retrospectively.

Similarly a person involved in a music therapy program may not always begin from a point where they identify that they have limited insight into their responses, feelings or actions. It is only when the person embarks on the therapeutic process that they experience an increased sense of clarity or insight. The client’s ability to reflect upon and or describe this process may accordingly develop as the program continues. The client therefore does not necessarily begin from a place where they realise they need or want to change, however as the process occurs the person may experience increased insight which allows them to describe a period of greater insight, power or a time that they needed to change. This realisation may therefore result in the person being only able to identify change or a need retrospectively. In this respect a person involved in a program may only be able to describe a sense of program ownership or the acquisition of skills, including participatory skills, as the program continues. This development assists further in their process of change or empowerment. This therapeutic process therefore supports the use of empowerment and music therapy with people who, at times, appear unable to participate, have limited decision-making abilities, or who have high levels of resistive behaviours. Such programs however may consist of slow stream work.

Murrell (1977 cited in Vogt & Murrell, 1990) identified two types of empowerment: self-empowerment is the ability to empower oneself; and interactive empowerment is the process of creating power with others. Empowerment results in empowered behaviour and empowering behaviour, leading to the realisation of power by more people rather than the redistribution of power among people. Self-empowerment and interactive empowerment must co-exist for empowerment to occur. To become empowered one must empower oneself; this occurs through collaboration between people (Kieffer, 1984; Rappaport, 1984; Shields, 1991; Vogt & Murrell, 1990).

Empowerment and music therapy

During music therapy practice the client and therapist frequently experience empowerment. The idea that empowerment is intrinsic to and a consequence of music therapy practice is suggested. This idea is supported through the frequent use of empowering action dimensions in music therapy practice as described in music therapy literature, clinical work and published case studies. These dimensions appear to be used to form and inform therapeutic processes employed by RMTs.

Furthermore prerequisites or integral phenomenon of empowerment and music therapy are evident. Firstly both involve a participatory process. This means that for music therapy and empowerment to occur, the people owning the experience or program must participate in the processes involved (Brown, 1991; Bruscia, 1999; Kieffer, 1984; Nordoff & Robbins, 1977; Robbins & Robbins, 1991; Rappaport, 1984; Wheeler, 1999). For example during music therapy if a piece of music is being played to the client however the client chooses not to participate through not engaging in the process of listening to that piece of music, the music may have little to no therapeutic effect.

The ways in which and the types of participation during music therapy and empowerment processes, of course, vary and the variation depends on a number of factors including the level of and repertoire of skill brought to the clinical context by the therapist and client. Another factor is the way in which both the therapist and client feel supported and valued in their clinical work. For example the RMT benefits from adequate professional support from colleagues, while the client may respond to support in the form of validation and affirmation from the therapist. This support, described here in the form of recognising and valuing people’s uniqueness, assists in greater levels of therapist and client participation.

Secondly, people who participate in music therapy and empowerment develop a sense of ownership of the processes involved and the outcomes resulting from their experiences. The level
of ownership of these processes will vary from client to client, therapist to therapist. For example songwriting is a method variation through which people can express and document their feelings and thoughts. In a clinical situation the therapist assists in facilitating this experience through, in a reduction of the procedure, the completion of two steps. Firstly through the provision of the opportunity to engage in this method, and secondly through the completion of the song. Frequently when this method is used both the client and therapist participate through listening, responding, sharing and creating. It follows then that both client and therapist, at some point during this process, co-own aspects of the song. During song-writing the actual song that is owned, may be audible and or legible, however when considering other music therapy methods, for example the receptive method the entity owned may be less tangible and may consist of one phenomenon. For example when working with children with profound multiple impairments or a person in a coma, the response that they own, and participate through, may be a physiological or emotive response. It follows then that for music therapy to exist the participants, that is the therapist and client's, must experience a sense of ownership.

Another phenomenon that is intrinsic to both music therapy and empowerment is that change, commonly described as growth, occurs. For empowerment to exist, collaboration must occur (Kieffer, 1984; Rappaport, 1984; Shields, 1991; Voge & Murrell, 1990). Collaboration requires interaction. This usually involves a shaping of responses depending upon the response of the person with whom you are collaborating or interacting with. This type of change or interplay forms an integral part of music therapy practice. This can be illustrated when reflecting upon two types of relationships that may be established during practice, that is the relationship between the therapist and client, and the relationship between the client and the music. For example when working with a client who is grieving the therapist will respond to the client’s feelings, for example this may entail a response of empathy. Another example is of the dynamic interplay that can occur when the therapist and client improvise together. When considering the relationship established between music and the client, change may occur in many forms. One example of this is a physiological response or change. For example when the client is entraining to music of a slow tempo the client's heart rate may slow down and the respiratory rate decelerate.

While acknowledging that empowerment exists in different forms, Brown (1991) outlined several action dimensions of empowerment. They are to:
- affirm people's humanness and uniqueness;
- link people with resources and hence, open up greater life opportunities;
- provide an open space, that is to give people the opportunity to regain a sense of control over their lives and environment;
- establish a sense of togetherness and to connect people with each other encouraging them to work together;
- legitimise or validate individual or group experiences;
- develop a heart for justice and compassion, a mind for analysis and hands for skilful, sensitive and disciplined action (pp. 4-12).

O'Hara and Harrell (1991) outlined a number of strategies that assist with empowerment in the field of rehabilitation, including:
- asking questions that are meaningful to the person;
- assessment of the whole person, that is the assessment of the person's abilities and developing areas in the context of his or her social system;
- acknowledgement of the individual as a unique person;
- provision of information and feedback from the therapist and other sources, for example from peers and family members;
- advocacy of the client's needs and rights;
- sharing the responsibility of the program between the therapist and client.
These strategies provide insight into values that are implicit in empowerment. The ways that these values may be translated to relate to therapy, or more specifically music therapy, include:

a) The recognition of quality between the therapist and client and accordingly the valuing of people’s unique abilities and sense of individuality. This is evident in music therapy literature relating to work with children with special abilities.

b) The recognition and valuing of people’s social systems and the notion that change within one social unit or system, will impact upon other formal and informal social units and networks, for example this is acknowledged when working in correctional facilities, and when working from a family-centred model in paediatrics and aged care. It is also recognised and valued when working in community-based palliative care.

c) The belief that all people possess abilities, including the capacity to grow, change and determine the ways in which and the extent to which this occurs. This is evident in many fields of music therapy practice including special education, disability, community work and palliative care.

d) The belief that as part of therapy the therapist will also experience change.

Additional examples of the ways in which RMTs use methods and procedures that are empowering and the ways in which RMTs can conceptualise their practice as empowerment can be found in music therapy literature. Literature also demonstrates the ways in which the action dimensions form part of our practice and consequently lead to empowerment.

An example of the therapist experiencing self and interactive empowerment is evident in a case study described by Shoemark (1991). In this publication Shoemark describes the use of improvisation with a young boy attending a residential education facility. She explained that during the improvisational phase, a small drum was used to provide the child with equal opportunities for creativity and participation. Through this interplay of creativity and participation, both participants had the opportunity to experience a sense of togetherness and an open space in which to control their creativity and participatory intent. This experience could therefore be described as empowering.

Similarly Clive and Carol Robbins (1991) described a case study where they began what they described as a journey together with an adolescent attending individual music therapy sessions. The sense of shared responsibility and experience in this description corresponds with empowerment dimensions described by Brown (1991), and O’Hara and Harrell (1991).

When working in the paediatric context Robb (1999) described that opportunities for choice during music therapy served to empower and renew a child’s sense of independence. She maintained that this was possible while using musical activities, instrument selection and instrumental improvisation.

In the same way that no one can empower someone else (Brown, 1991; Rappaport, 1984), during music therapy the practitioner is not able to make the person feel, act, change, think or grow. The therapist simply facilitates the opportunity for phenomenon or behaviours to occur within or by the client (Aldridge, 1993; Bailey, 1984; Bruscia, 1999; Davison, 1999; Davison & Kennedy, 2000; Davison & Edwards, 1998; Edwards, 1995; Erondnez, 1990, 1992; Robb, 1999).

Vignette one
Josephine was referred to music therapy for a number of reasons including a need for self-expression. She was aged in her forties and had been residing in an institution for most of her life. She had not developed any verbal skills, yet at times of distress or heightened excitement she was very vocal. She had multiple severe impairments and frequently engaged in self-injurious behaviour. Josephine had attended group music therapy for 12 months and was now beginning to develop a range and pattern of communicative vocal responses. These responses included a low guttural sustained sound, an ascending vocal glissando and a short detached "ergh" sound preceded by a tightening of upper limb muscles and a deep breath.
During each improvisation the music therapist would begin by positioning herself on the floor next to where Josephine sat. The therapist would then encourage Josephine to vocalise. The music therapist would sing Josephine's name; this would usually be followed by the therapist vocalising in a style similar to that of Josephine's vocalisations. For example the therapist would often begin by grunting a low guttural sound and then follow this with an ascending vocal gisando. This invitation was followed by a period of waiting and listening. It was during this time that Josephine would choose whether or not to vocalise; it was also during this time that the therapist would assess whether or not Josephine was going to respond vocally. If Josephine vocalised the therapist would respond with another vocalisation and positive reinforcement. Frequently the therapist would provide Josephine with feedback relating to her vocalisations.

This process of facilitation or affirmation occurs in many different forms during music therapy practice and with diverse populations including people with severe, multiple impairments, people with dementia and people in the final stages of their lives (Davey & Kennelly, 2000; Clair, 1991; Kennelly & Edwards, 1999; Robbins & Robbins, 1991). In the field of disability, Paul Nordoff and Clive Robbins (1977) described it as the therapist helping the client control and organise his or her sounds so that they can be developed further. They maintained that this leads to increased levels of expressiveness and inter-responsiveness. These are qualities that assist with collaboration and participation.

Through this practice the client is provided with the opportunity to respond in a way that is authentic or true to himself. They are provided with space and encouragement to determine the ways they want to respond or act in their environment. This aspect of music therapy practice corresponds with two dimensions of empowerment as outlined by Brown (1991). First it corresponds with the dimension of affirming people's humanness and uniqueness and second with the dimension that aims to provide an open space, so as to give people the opportunity to experience a sense of control over their lives and environment. As can be seen in vignette one the music therapist also provided information and feedback to the client. Information sharing is a dimension of empowerment and standard music therapy practice.

This affirmation during music therapy involves a systematic application of choice-making opportunities that are provided to the client musically, behaviourally and or verbally. These opportunities lead to the provision of actual or perceived opportunities for the client and therapist to engage in behaviours, cognitions and or opportunities to experience feelings. Once this occurs the therapist will usually acknowledge the client's contributions verbally, musically or behaviourally. This affirmation and valuing occurs in many different ways. Bruscia (1999) has described this process in the form of imitation and synchrony during improvisation. Lecourt (1991) described it in the form of recording the client's contribution and then playing the contribution back to the client. O'Callaghan (1990) affirmed and valued the client's contribution through the incorporation of a song subject suggested by the client into a song. This in turn leads to self and therapist validation and further opportunities for therapist and client choice.

This systematic process of choice provision and affirmation provides opportunities for the client and therapist to act powerfully and interact powerfully with one another. When the therapist offers the client the opportunity for choice, in addition to affirming the person's humanness and uniqueness, the therapist is offering the client the opportunity to experience a perceived sense of control or an opportunity to exercise actual control during the session. In music therapy literature it has been noted that music therapy has been described as a means that assists in the restoration of control through the experience of choice (Albridge, 1993; Cowan, 1991; Gumbrecht, 1991; Robb, 1999; Skewes & Thompson, 1998; Winslow, 1986). This is realised in a way that encourages the therapist and the client to respond in another powerful way, more specifically in a way that provides another opportunity for choice. Music therapy therefore
encourages both the therapist and the client to respond in ways that are self-determining. In this respect both empowerment and music therapy are congruent, dynamic and a means of creating power.

Other similarities between empowerment and music therapy practice are evident. In an article by Ely and McMahon (1990) a music therapy program that assisted people with severe impairments in accessing community based creative arts programs was described. This music therapy program directly translates to the dimension of empowerment that seeks to assist people in establishing a sense of togetherness and encouraging them to connect and work together (Brown, 1991). This notion is also encapsulated in writings of Pavlicevic (1990). When examining improvisation in a therapeutic context she aptly described the interaction as an experience that consists of a musical space for sharing between the therapist and client. When exploring the interactive process of healing during music therapy Erdonmez (1990) described that trust in the therapist occurs when the client feels valued and accepted. She specified that trust occurs once a connection between the therapist and client has been established and that this sense of connectedness leads to therapist and client growth. This theoretical notion integrates many action dimensions and premises of empowerment into music therapy practice.

Vignette two

Billy, a 16 year old male had been admitted to hospital due to serious complications resulting from a reaction to medical treatment. This patient had a history of generalised seizures and anorexia. His current treatment included a liver transplant from which he was recovering.

When the music therapy student (MTS) first met the patient he asked if he would like some music therapy, he replied "Not today!" The student had no further contact with the patient until four days later when Billy asked her to return for music therapy.

When the MTS and patient met, the student offered the patient the opportunity to actively participate or to listen. The patient chose to actively participate. His request was whether there were any songs that he wanted played. The patient requested a number of popular songs by a number of popular artists. Two songs were sung and discussion that focussed on videos and events in popular music culture occurred. The therapist and patient met several times after this first session.

During the program, the patient shared music that he liked and wished to sing. Sometimes he would say "Can’t you play any louder?" the student replied that she could, and would proceed to strum the guitar and sing at a louder volume. During two sessions the adolescent requested a song called "Detachable Penis", remarking "this is what I wish I had". In subsequent sessions the patient shared with the student other concerns relating to his physical self plus feelings of being "trapped" by his parents. He remarked that "they want to control everything I do."

In vignette two, the MTS sought to affirm the patient’s humanness and uniqueness through the process of music therapy. The patient’s choice of not participating in music therapy resulted in the patient not receiving music therapy. It could be argued that this affirmation of choice, in part, then resulted in the patient’s request for music therapy four days later. The request for the student to play louder was also possibly a reflection of the patient’s sense of powerlessness and sense of being out of control. The song ‘Detachable Penis’ provided a way that the patient could reveal some of his concerns about his body, about resuming his life and about regaining a sense of control. Previous to the first session the patient had requested that the song be played in his room however his parents discouraged the song from being played. Similarly he requested that it be played on the hospital radio however this was also discouraged. The playing of the song during music therapy affirmed and legitimised his concerns and individuality. During music therapy he was provided with the opportunity to express while also having his feelings of powerlessness with regards to his family acknowledged.

During empowerment and music therapy people have the opportunity to realise authenticity. This belief is embodied in statements written by music therapists who acknowledge the role of
music therapy in assisting clients in retaining identities or roles that are authentic to themselves (Daveson, 1999; Edwards, 1995; Erdonmez, 1990; Robb, 1999; Robbins & Robbins, 1991; Skewes & Thompson, 1998). For example when working in a hospital, patients and their family members are enabled with the opportunity to remain 'people' rather than 'patients' during music therapy (Daveson, 1999; Daveson & Kennelly, 2000; Dun, 1995; Kennelly & Edwards, 1997; Lane, 1992; Robb, 1999). Music therapy goals that aim to assist participants in improving the ways that they can interact with and access opportunities, social situations, people or events can frequently be found in music therapy literature (Edwards, 1995; Ely & Scott, 1994; Ely & McMahon, 1990; Robbins & Robbins, 1991; Skewes & Thompson, 1998). Nordoff and Robbins (1995) state that music can provide the space and support necessary to develop communication skills and personality. This can lead to more authentic interactions between the client and therapist, and client and others.

Vignette three

Gheeto, a ten year old had recently been transferred from the Hospital's Intensive Care Unit to a specialist unit in the Hospital where she was to receive further treatment. During the last three weeks since her admission she had been involved in invasive and painful procedures and now, bedridden, staff were talking about the patient's forthcoming treatment within close proximity of the patient. Gheeto, while not invited to be part of this conversation, overheard many aspects of the conversation.

Shortly after this conversation had ceased, Gheeto was involved in her first music therapy session. Upon entering Gheeto's room the music therapist introduced herself and her role to Gheeto. The music therapist then remarked to Gheeto that she looked very scared and asked if there was something worrying her. At this point Gheeto burst into tears. The therapist asked Gheeto if she could explain what was upsetting her. Gheeto explained that she didn't want to go and have an ultrasound and that she was very scared. Later in discussion it was realized that even though she hadn't been told that she was to have an ultrasound, she had overheard that she was going to require one that afternoon. During discussion Gheeto explained that she did not know what an ultrasound was and that she was imagining it to be very painful. The therapist explained, with the help of one of the nurses who had entered the room, what an ultrasound was and what would happen during the ultrasound. The therapist asked Gheeto if this explanation assisted in helping her feel less scared and upset she replied "yes". The therapist then began to play a familiar piece of music to assist Gheeto in relaxing.

Through asking meaningful questions, assessing the whole person, restoring an authentic role to Gheeto and through the sharing of information, Gheeto's anxieties and fears relating to the unknown were lessened. She was encouraged during the session to ask staff and her mother (her only familial support at the hospital) questions relating to her treatment and condition. The therapist modeled this during the session when she asked medical staff, on behalf of the patient, what would be involved during the patient's ultrasound. The therapist later discussed her concern with staff that patient details were being discussed within an audible range of the patient however no attempt to include the patient in these conversations was occurring. It was explained that this was resulting in heightened levels of anxiety. Strategies for this to be avoided were discussed with medical and allied health staff.

The restoration of authentic roles is also applicable to the music therapist. Qualitative research paradigms that encourage the therapist to share with the reader aspects of their personal selves, including in the form of their responses to their work, are being used in the field of music therapy (Wheeler, 1999). Reviewers from National and International refereed music therapy journals are also encouraging music therapy authors to include aspects of their own experiences in articles they submit for publication. The acknowledgement of the shared journey between the client and therapist is receiving focus in contemporary writings (Brown, 1997;

Acknowledgment of the personal self has also been referenced in music therapy supervision literature. This can take the form of the music therapy supervisor encouraging the music therapy student to reflect upon his or her own personal responses evoked during clinical placement (Brown, 1997). This process can be linked to the dimension of empowerment, outlined by Brown (1991), that aims to develop a heart for justice and compassion, a mind for analysis and hands for skilful, sensitive and disciplined action. RMTs are required to use skills of insight and empathy to engage in therapeutic work; to use skills of analysis and empathy to understand the impact of events on clients that we are working with; to use skills of insight and honesty to understand the impact of work-related events on us as therapists; and to assist in and engage in action that is skilful, sensitive and disciplined. This best practice may lead to the legitimisation of the therapist’s individual and group experiences and the linking of therapist’s with resources. This may lead to further individual and collective professional empowerment.

Why integrate empowerment with music therapy?

Tayer and Burns (1993) write that the responsibilities of the health professional often transcend the obvious. Structures within which music therapists work are not always equitable and frequently music therapists may experience, in a similar way that clients who access our services, a sense of devaluation. While acknowledging that empowerment exists in different forms, Brown (1991) maintains that through the use of empowerment people can act in powerful and empowering ways. Empowerment assists in self-validation and growth; this assists with the development of our programs and of our profession. The acknowledgement of our own experiences may provide us with a greater understanding of our clients’ experiences hence extending our clinical work. Through a conscious blending of empowerment with clinical methods therapists are provided with opportunities to enable themselves and the people accessing their programs. This process of enabling may lead to a sense of dynamism within the therapeutic context and beyond.

Acknowledgement

The author wishes to acknowledge the contribution of Carmel Davison in the development and understanding of empowerment and music therapy described in this paper.

References


