Reflections on Music Therapy and Arts in Health

Hilary Moss

Abstract

This article is a structured reflection on the author's experiences of both music therapy and arts and health work within healthcare services and an exploration of the relationship between these two distinct but related practices. It offers examples of various models of using music in healthcare settings, presents definitions of both music therapy and arts and health, and finally explores three key issues that arise when arts and health practice and music therapy meet in healthcare settings. The aim is to raise questions and encourage music therapists to reflect on how they can best interact with arts and health practitioners in their workplaces as well as how they can most effectively define their own work.

Background – the context of this article

Having qualified as a music therapist, and with subsequent experience of working in mental health services and services for older people within a psychodynamically informed therapy team, I now work in arts and health, as Arts Officer at The Adelaide and Meath Hospital in Dublin, Ireland. This is a large academic teaching hospital and the arts programme includes a performance programme in the atrium, recorded music as part of hospital design, music therapy in psychiatry and stroke services and a CD library accessible to patients, as well as visual art sessions, creative writing workshops and exhibitions. Following consultation with patients and staff, four broad aims have been developed for the arts service:

1. To enhance the environment
2. To explore the therapeutic nature of the arts through participatory sessions for patients
3. To raise awareness of the arts and make the arts more accessible to staff, patients and hospital visitors
4. To promote local artists and build links with the local community.

Three examples follow of music used in healthcare settings which are not music therapy but bring many benefits to service users.

Example 1

> *Jim attends a drop-in centre for people with mental health problems. He has a diagnosis of paranoid schizophrenia and has been unwell for a long time. He has spent time in hospital and is now living in supported accommodation in the community. Jim finds it difficult to engage with any health professional and has little trust of mental health services. He attends a MIND day centre once a week. He typically presents at the centre with poor hygiene, hair matted, wearing dark glasses and with a hat stuck to his head with glue. He is quite an eccentric figure and at times somewhat aggressive to staff. Jim plays the guitar. Once a week in the MIND centre there is a music group where clients bring their instruments and jam together. A musician (who recently left university with a music degree) volunteers at the centre and facilitates the music group. Jim and the volunteer musician make music, improvising together on guitar and trombone. There is a strong connection. Jim has a positive experience and says that the music is good. This group is one of the reasons Jim comes to the centre and keeps coming back. The music group is a focal point for him in his week and is one of the*

few positive interactions he has with services.

Example 2

The Irish Chamber Orchestra attend the Adelaide and Meath Hospital in Dublin once a month to perform as the hospital's "Orchestra in Residence". Musicians from the orchestra perform a short programme and talk about the music, their lives as musicians and the instruments. The sessions are light and fun but extremely high quality and very professional. The musicians have tea with patients after the events. The hospital Arts Office carried out research to explore the benefit of live music for patients (Moss et al 2007). Briefly, the results indicated that patients and staff found live music highly beneficial in a range of areas. In particular, listening to live music helped patients to relax, distracted them from worries, lifted their mood and encouraged physical movement. There were overwhelmingly positive reactions to the role of live music in an acute hospital setting and very few negative. A large number of both patients and staff indicated that they felt extremely anxious or stressed when attending hospital and that the music helped them to cope. Some respondents found that the music made them sad or reminded them of someone in their family who had died and the researchers recommended that these people should be supported by a clinician (e.g. a music therapist or nurse) when this sort of experience occurred.

Example 3

In the Women's Health Unit of a hospital gynaecology department, two treatment rooms used for colposcopy investigations were redesigned. A number of techniques were used to enhance the environment for patients and make the treatment rooms less intimidating and clinical. Lighting, new curtains, wall colour, art work and furnishings were used to change the image of the rooms. Recorded music was used to create a softer, more relaxing atmosphere and a DVD player was installed in the ceiling above the treatment table showing images of nature and relaxing scenes. In the MRI scanning department of the same hospital, patients are routinely invited to bring their own favourite CD to listen to whilst having a scan.

The three examples above all involve music in healthcare settings. All have benefits for patients. They are not music therapy as it is usually understood in a professional sense, but what are they? How do we define what is music therapy and what is not? Are our definitions useful or restrictive? Are they relevant for patients and staff or confusing? Do the examples above pose a threat to music therapists because they involve musicians who are not trained therapists working in healthcare settings? How do we select musicians to work in healthcare settings if they do not have a music therapy training?

Definitions

In the UK music therapy is registered as a profession with the Health Professions Council, with eight training courses currently approved by the HPC and leading to qualification as a music therapist. In Ireland there are MA courses in music therapy, art therapy and drama therapy.

The arts and health movement is growing and strong in many areas, but as yet there is no centrally recognised qualification in Arts and Health. Whilst there are a number of professional development courses in the UK for artists wishing to work in healthcare settings, arts and health practitioners, whilst often very experienced, have a relatively less developed professional identity.

The Arts Council of Ireland has attempted to define the difference between the arts therapies and arts in health practice:

> Arts therapies integrate the experience of a given art form with the theories and practice of psychology, psychotherapy and psychiatry as a unique form of therapeutic intervention. Arts practices have a focus on artistic processes and artistic outcomes for their own sake.
>
> The distinction between the two is sometimes difficult to make, as many arts therapists are also practising artists. But it is important, since art, music, drama or dance movement therapists are qualified health professionals equipped to deal with therapeutic work.
>
> We make a clear distinction between arts practice, whose primary goal is the experience of art or the production of art, and arts therapies, whose primary function is therapeutic.

> This is a continuing area of discussion in arts and health work and should be clarified in relation to each project.
>
> (Arts Council of Ireland 2003: 104)

In practice, however, it is my experience that the primary difference is that arts in health practitioners define themselves as concerned only with the art for its own sake whilst arts therapists are defined as meeting clinical and therapeutic goals through their art form. Nevertheless, the overlaps to be found in practice are immense and some in the field would question these basic definitions.

An example of such confusion follows:

> *A weekly recreational art group takes place in the Age Related Health Care Unit of our hospital, facilitated by a visual artist. Mary is a patient who has had a stroke. She has painted all her life but now has no movement in her right arm and cannot speak. She is trying to paint with her left arm and is crying during the session. The artist deals with the issues arising sensitively within her experience and remit and the session seems very meaningful for Mary. I am left wondering if art therapy might be useful for this patient. As the session closes, a healthcare assistant comes into the room and says "That's a lovely painting, Mary" – an inappropriate intervention given the mood in the room. The artist and I discuss the issue afterwards, and I find myself advising the artist about boundaries and the need to make the space safer for patients by asking staff not to enter the room. Whether a recreational or therapy group, such issues are equally important.*

Issues

At this point I wish to turn my attention to three key issues which arise from reflecting on the role of music therapy and arts and health practice in healthcare settings:

1. Professional qualifications and training
2. Flexibility and limitations of the role of the music therapist
3. Policy making and strategy in arts and health

1. Professional qualifications and training

The Arts Council of Ireland recently commissioned me to take part in the research and development of a training course for artists wishing to work in healthcare settings[1]. This was in response to a need expressed by artists in residence of all art forms who were finding that they needed training and development for their work in hospitals. I discovered in the course of the research that whilst there are many examples of good practice in arts and health work, the existing literature in this area was extremely sparse and it was difficult to find arts and health training courses internationally. However, articles were found within the arts therapies literature which were clearly useful in relation to setting up trainings in the use of the arts in healthcare, and we recommended that developers of this course could draw useful material from the work already done by the arts therapies professions.

For example, Wadeson (2004) addresses the issue of professionalism and ethics for art therapists working in healthcare settings. This would seem to be an issue equally relevant for arts and health practitioners. Seiden *et al* (1989) describes art therapy training within a school of professional art, in which students are taught human development, art and studio art skills, and discusses how to integrate such a course into a traditional school of art. This is relevant in terms of developing arts and health training within an existing art college and the proposed course design.

Teasdale (1993) looks at the role of placements in art therapy training and addresses issues such as the constancy of placements, supervision and adequate facilitates for training in healthcare settings for art therapists. This would again seem closely relevant to the needs of students on art and health training courses.

Three books on art therapy were also found to be highly relevant: Waller 1993, Rubin 1999 and Rubin 2001. All three contain chapters on various aspects of both training art therapists and using art in a range of health care situations. For example Rubin (1999) breaks down the key issues for artists working in healthcare into chapters which include an outline of what art therapy is, its rationale and history, vignettes of practice, consideration of cultural perspectives and societal issues, accountability, the therapeutic

[1] The commission was awarded to a consortium comprising The Adelaide and Meath Hospital Arts Office, the Institute of Art and Design in Dun Laoghaire, Dublin and Create, the National Development Agency for Collaborative Arts.

framework, evaluation and contexts of work – all of which could be relevant to the content of an art and health training course.

As a music therapist, my main observation from this experience was the difference between the level of training currently available for artists working in healthcare settings and the level of training that arts therapists receive before being qualified to practise. The rigorous registration of arts therapists is also significant and important in this respect. The hope is that the new arts and health course in Ireland (to be piloted in September 2008) will be the start of such training and professional development for arts and health practitioners in Ireland.

2. Flexibility and limitations of the role of the music therapist

From a practical perspective, it seems that the music therapy profession has limited the role of music therapists to the point where they are absent from some of the areas of healthcare that concern themselves with music. Ansdell (2002) argues for a broader practice of music therapy, which he calls Community Music Therapy: '… a context-based and music-centred model that highlights social and cultural factors influencing music therapy'. Music therapists are specialists in using music within healthcare yet have professionally excluded themselves from such a role in many cases. The arts and health examples given above might be considered to raise more questions for music therapists than they provide answers: Are we clear abut our role? Do hospital managers and senior clinicians understand and appreciate our work? Could a music therapist advise on performance in hospitals or the incorporation of music into hospital design (without necessarily doing these things themselves)?

My own work as an arts and health manager is immensely informed by my training as a therapist. I am able to recommend interventions where appropriate and advise on the role of music in the environment as well as providing clinical supervision for music therapists working individually with patients. I train staff in how to use music in the environment and reduce noise pollution. I am not advocating any confusion of roles; rather that music therapists could be overall advisers, recommending the best musical intervention for the particular healthcare environment but also being open to whether music modalities other than music therapy might be most effective in a particular setting. Different ways of using music may be important in different settings and music therapy may not always be the most appropriate choice. Perhaps sometimes we limit ourselves in our definitions of our role as music therapists? The focus should always be on what the patients and the organisation need from music rather than on a protectionist approach to professional identities. Thus it may sometimes be more appropriate to have a performer than to have a music therapist within an organisation: we have to be mature enough as a profession to accept that possibility. Going a stage further, I would prefer (as a music therapist) to be involved in ensuring that the selected musicians are of a high quality and able to be sensitive to the needs of patients rather than excluding myself from the process because "it's not music therapy".

> On the one hand music and art therapy professions are recognised as established groups with their own frameworks for regulation, professional development and quality assurance. Yet their apparent focus on individual and medical models of health has meant that they are not always included in arts for health initiatives where these are underpinned by social and holistic approaches. This could lead to the possible marginalisation of art and music therapy professions from broader initiatives where they could offer valuable experience and expertise, such as in relation to the development of supportive frameworks for artists involved in arts and health work.
>
> (Daykin 2007: 85-86)

3. Policy making and strategy in arts and health

In Ireland, the Arts Council of Ireland has formulated clear policies regarding arts and health development but no such equivalent activity has been undertaken by the Health Service Executive. However, the arts therapies have made significant strides in recent years in developing recognition for the profession. The question arises as to the development of both arts and health activities and arts therapies and the need for a clear approach to both. At present limited funding creates a competitive approach between professions. Perhaps 'Arts and Health' should be a broad umbrella term under which both arts therapies and other forms of the arts in healthcare belong.

> There is in general a lack of understanding between arts therapists and arts in health practitioners about the unique contribution that each makes to improving and enhancing health services, and what they can learn from one another's practice'
>
> (Arts Council England 2004 cited in Daykin 2007: 85)

Conclusion

This article has aimed to explore and reflect on the role and definition of music therapy in the context of my own experience of working in both fields. This experience has been twofold – on the one hand, I find myself straddling the arts and health and music therapy 'worlds' with one foot in each camp and feeling that I do not 'belong' in either. On the other hand, the diversity of practice I have encountered, the creativity and flexibility available to me and the opportunity to use my art form in many different ways has been refreshing and exciting. Alongside these experiences, I have concerns about professional boundaries and identity as well as some concern for standards of care and treatment for patients.

I hope these reflections have raised questions and that they will help music therapists both to respond to and to relate to arts and health developments in their services and organisations. Music therapists have a rigorous training and are highly skilled professionals with much to offer the arts and health field.

> Health musicking may take myriad forms, may occur on a continuum from 'therapy' to 'ordinary cultural participation'. Indeed care might be taken to think about how these forms of musicking may be co-ordinated in a mutually supportive way and how music is used to re-establish wholeness between mind and body.
>
> (Batt-Rawden *et al* 2007: 78)

To conclude I would like to pose a series of questions for music therapists to consider when exploring this issue:

- How do I define music therapy? How do I define my own practice and approach?
- Is this approach suitable for the healthcare setting where I work?
- Do patients/clients need other forms of music/arts that are not currently being provided by the music therapy service?
- Does the organisation have environmental or social needs which can be addressed by musical intervention or other art forms other than the music therapy service?
- If so, is this anything to do with me as a music therapist? What is my role in advocating for these additional services?
- How do I react when an arts and health project is suggested in my organisation?
- Do I identify myself more as a musician or a therapist?
- How can I keep my creativity and flexibility alive in the way I use music in my workplace?

Hilary Moss *is a qualified music therapist, currently employed as Arts Officer at The Adelaide and Meath Hospital, Dublin. She has an MBA in Health Service Management.*

References

Ansdell, G. (2002) 'Community Music Therapy and the winds of change'. *Voices: A World Forum for Music Therapy* 2(2). Available online at http://www.voices.no/mainissues/voices2(2)ansdell.html

Arts Council England (2004) *Arts, health and well-being: a strategy for partnership*. Draft for consultation, November. London: Arts Council England

Arts Council of Ireland (2003) *Arts and Health Handbook: A Practical Guide*. Dublin: The Arts Council of Ireland

Batt-Rawden, K.; Trythall, S. & DeNora, T. (2007) 'Health musicking as cultural inclusion'. In J. Edwards (ed.) *Music: Promoting Health and Creating Community in Healthcare Contexts*. Newcastle, Cambridge Scholars Press.

Daykin, N. (2007) 'Context, culture and risk: towards an understanding of the impact of music in health care settings'. In J. Edwards (ed.) *Music: Promoting Health and Creating Community in Healthcare Contexts.* Newcastle: Cambridge Scholars Press

Moss, H.; Nolan, E. & O'Neill, D. (2007) 'A cure for the soul? The benefit of live music for patients in acute hospital'. *Irish Medical Journal* 100(10): 634-636

Rubin J.A. (2001) *Approaches to Art Therapy: Theory and Technique* (2nd edition). London: Brunner-Routledge

Rubin J.A. (1999) *Art Therapy: An Introduction*. London: Brunner/Mazel

Seiden, D.; Callisch, A. & Henley, D. (1989) 'Graduate art therapy training within a school of professional art'. *The Arts in Psychotherapy* 16(1): 21-27

Teasdale, C. (1993) 'The role of the clinical placement in art therapy training: toward consolidating our professional identity'. *The Arts in Psychotherapy* 20(3): 205-212

Wadeson, H. (2004) 'Guest editorial – to be or not to be licensed: is that the question?' *Art Therapy: Journal of the American Art Therapy Association* 21(4):182-183

Waller, D. (1993) *Group Interactive Art Therapy: Its Use in Training and Treatment*. London: Routledge