The healing power of music: An IPA of practitioners’ experiences towards a unified musical intervention framework

Sarah Williams

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ABSTRACT

Music’s healing properties have been mirrored through an array of research (Groß et al., 2010; Mandel et al., 2007; O’Callaghan, 2011; Schmid & Ostermann, 2010). Despite this, there remains a lack of clarity surrounding how different musical disciplines work.

In order to develop an understanding of how musical approaches implement change in their patients, a variety of music practitioners were used as participants in this study. The following disciplines were represented by participants: Music Therapy, the ‘music for health’ approach and Sound Therapy.

Semi structured interviews were used to guide the discussions and an IPA analysis was conducted on the transcripts.

Despite slight divergences in individual practitioner’s stances, a model has been created outlining the common features of all musical approaches analysed. This model consists of two main dynamics: connection between the practitioner and the patient and multifaceted adaptation. Within these dynamics is a cyclic process of three stages: anticipations, interactions and alterations. Accordingly, a parallel between musical interventions is identified, providing a more profound understanding of the underlying philosophy of musical disciplines.

Slight divergences between the approaches analysed are also discussed, along with the implications for the evaluation of these approaches.
Introduction

Music Therapy practice is the strategic use of music revolving around underlying aims to help an individual in their pathology. These aims are shared with biomedical disciplines (Abrams, 2011) and allow a more measurable outcome. Music Therapy can alleviate the harmful experiences of being diagnosed with an illness and improves functioning in various areas (Erkkila et al., 2011; Jones & Van de Eerden, 2008; Kusatz et al., 2005; Letts et al., 2011; O’Callaghan, 2011; Sherratt et al., 2004). The use of randomised controlled trials provides more prestigious support for Music Therapy at a time when evidence based practice is required. Sen et al. (2011) do however point out how blinding was jeopardised in Erkkila et al.’s (2011) study. Therefore, it is evident that the evaluation of musical interventions may be cumbersome and further research into the area is required.

‘Music for Health’ is a different discipline, where trained musicians take part in highly interactive sessions of music with patients. This takes place at the bedsides of patients and with groups of patients in a hospital setting. Preti and Welch (2011) recognised that this approach helped relaxation, distraction and verbalisation. These outcomes are often found in Music Therapy practice too (Hilliard, 2006), highlighting an aim of the present study, which is to clarify the differing approaches available. Rather than having specific clinical aims, this approach has the core aim of changing the environment (Preti and Welch, 2011). The absence of clinical aims generates evaluation difficulties and dissatisfaction with the approach from others (Dileo & Bradt, 2009). The question of how these approaches differ, apart from their dissimilar use of aims, is posed, since a similar setting to music therapy practice is used here. The present study delves into the experiences of these practitioners to obtain an outlook as close to the truth as possible regarding the phenomena involved in these contiguous disciplines.

Sound Therapy or sound healing is another approach, with an emphasis on holism. Snow (2011) describes how Sound Therapy embraces the mind and body by applying sound vibrations directly onto the body of an individual to generate a state of harmony. Boyd-Brewer and McCaffrey (2004) found audible sound vibrations to improve pain levels and general wellbeing within a nursing environment. Sound Therapy also uses the core aspects of sound, involving vibrations, waves and frequency. Crowe and Scovel (1996) propose that Music Therapy and sound healing are related and that a continuum of sound and music exists. Again, the present study investigates the parallels and variances between these different musical approaches.

These interrelated concepts of musical intervention have been found to produce normalcy for individuals in an unfamiliar clinical environment. The ‘music for health’ framework has been identified as a distraction from clinical procedures (Preti & Welch, 2011) with music being used instead of sedation for clinical procedures. Evidently, the environment is less threatening for the patient through this musical technique. This supports Lazarus’ (1991) transactional stress theory, which denotes how stress depends upon the meaning of a stimulus to the perceiver. Since music can change the connotations of an environment and therefore of a stressor, the transactional stress theory is supported. The present study
illuminates how a stressful situation may be perceived differently through the use of music. Music Therapy’s structured use of clear objectives will be compared with the less structured nature of Music for Health and Sound Therapy, to acquire an understanding of any parallels or differences in how this improved environment takes place. Further enhancements are also explored, such as communication.

Another fundamental facet of musical approaches is its impact upon communication. Previous research has found that music improves communication for individuals with a multitude of problems, including cancer and Alzheimer’s patients (Groß et al., 2010; Mandel et al., 2007; O’Callaghan, 2011; Schmid & Ostermann, 2010). This significance of communication is also reflected in the relationship between the practitioner and the patient. It has been identified that a trusting, communicative relationship between the practitioner and the patient is important (Intven, 2010; Langston & Barrett, 2008). O’Callaghan et al. (2011) point out the need for further research focusing upon the ‘therapist effect’ to determine the qualities required by the practitioner to produce effective therapy. The present study uses the experiences of practitioners to gain access to what they believe is effective practice. Implicit in this are the principal components employed by practitioners including how they communicate with their patients. Using the lens of practitioners’ subjective experiences eliminates the issue of inconsistent statements of child patients which has provided a problem in previous research (O’callaghan et al., 2011). Due to this increased communication, the patient’s identity can manifest itself.

Self-perception is a key element to musical interventions, with research by Lamont (2002) placing emphasis on how music can form part of one’s identity. The personal significance of music is therefore apparent and suggests the therapeutic power it can hold. Winnicott’s (1972) theory of transitional phenomena suggests how music can provide an alternative way for the patient to exist, exemplifying how one’s identity can be shaped through the use of music. The therapeutic relationship between the patient and the practitioner is pertinent again here, described by O’Callaghan (2011) as a ‘human musical mirror’ allowing the patient to represent themselves in a new way. Lowis (2010) also highlights the relevance of self-actualisation as a result of music, showing further how self-perception can be altered through music. The present study aims to discover how music creates these experiences of self-discovery, through the eyes of a music practitioner. Whether the different musical disciplines vary in how they produce such effects, will be explored. An equal level of importance will be placed upon participants’ reports of their own self-perception and that of their patients, to gauge the connectivity of such processes. With this connectivity, comes the relationship between the participant and their patients.

Further to the communication between the practitioner and the patient, their relationship overall is stressed as being critical to the function of musical approaches. Building and sustaining relationships was found by Gold et al. (2007) to be a key objective to Music Therapy practice. The present study will analyse whether this is equally important for the music for health framework and for Sound Therapy practice. Buscia (1998) uses the key elements of musical experience and the relationships, which grow throughout this, to define Music Therapy. It follows that, the present study’s use of IPA works towards understanding these experiences and relationships, which take place in musical
interventions, from the perspective of the practitioner. A view of how this therapeutic relationship may vary throughout the participants will be seen.

The question of how interconnected different musical interventions are, is deep-rooted in the present study. Whilst the work of Daveson et al. (2008) advocates the concept of an indigenous Music Therapy theory, this will be considered with reference to the wider field of musical interventions. Hence, any common aspects of the approaches will be identified in the present study to allow for the possibility of a unified theory of musical interventions. An example of the confusion surrounding the relatedness of musical interventions is displayed by Sollner et al. (2000) who identified how the therapeutic use of music shares parallels with alternative and complementary treatment. Research by Mclean (2005) found that these alternative treatments can be considered to create additional stigma to illness, therefore it is important to clarify these different approaches in order to combat these negative connotations (Daykin, 2006; Department of Health, 2006). The necessity to integrate musical interventions is accentuated here, since clearness of how they correspond is required in order to eliminate comparisons with other non-musical treatments.

The continuous dispute regarding how to evaluate musical disciplines is addressed in the present study. The lack of randomised controlled trials in the Music Therapy arena has been pointed out by Silverman (2010). This demand for ‘higher quality’ research is understandable when considering the current state of the NHS health reforms (McDermott et al., 2012). Yet the personal nature of musical interventions requires a focus upon participants not statistics. This need to understand the individual is supported by Lee (2012) who describes how talking highlights matters which may otherwise remain unknown. This is essential when considering how musical interventions need to be better understood in the healthcare service. For a profound insight into evaluative issues, the present study assesses practitioners’ views regarding the evaluation of their work.

Pertaining to the methodology of musical intervention research, a multitude of quantitative research into the effects of music exists (Walworth et al., 2008; Nicholson et al., 2008; Gold et al., 2007; Ledger & Baker, 2007), in an attempt to meet the ‘gold standard’ of evidence based practice, required in healthcare today. Nonetheless, there remains a void to be filled in terms of music’s role in healthcare practice. Various measures still need to be fully incorporated into established research (Ledger & Baker, 2007) to provide a thorough view of musical interventions’ impact. Despite the high status of randomised controlled trials, there are pitfalls in the way this method represents musical interventions. DeNora (2006) advocates a less generalised attitude to evidence for the field of musical interventions.

In order to provide this less generalised approach, qualitative research displaying music’s impact upon individuals takes effect (Daykin et al., 2006; O’Callaghan et al., 2007; O’Callaghan, & McDermott, 2004; O’Kelly, 2007). This research enables a more particular understanding of music’s true influence upon the lives of individuals. Mixed method studies do exist demonstrating the effectiveness of musical interventions (Jacobsen & Wigram, 2007; Kern, 2007; Oldfield et al. 2003) which creates a balance between the two extremes of evaluation; yet, this type of study is sparse. The evaluation difficulties presented here create room for the views of practitioners in the present study to explicate
how they feel evaluation of their work should take place. This can be valuable for the country’s healthcare service to realise how their demands of evaluation may not be suitable for musical interventions.

The spectrum of musical approaches is under scrutiny in the present study, so as to grasp their impact upon the persona of individuals within a clinical setting. This stems from Lamont’s (2002) reference to how music is interwoven into our lives and contributes to our identity. This can act as a precursor to the positive effects of musical interventions displayed in previous literature. Additionally, Sacks’ (2006) reference to music’s power to shift an individual’s perception of time and space will be expanded upon in the present research, through the analysis of practitioners’ experiences. Research by Gold et al. (2007) suggests that specific techniques create the best impact upon the person, thus, this study endeavours to test this to see how participants explain music's impact and what determines this.

**Method**

**Design**

In light of the personal nature of this study, a qualitative design is employed. The importance of understanding the accounts of individuals provides a basis for qualitative research (Killick & Allan 2001).

The present study has analysed interview accounts using Interpretative Phenomenological Analysis (IPA). The interview questions have focused upon the processes used by practitioners in their practice and also the effect this has upon their patients. Semi-structured interview questions were used, formulated with the IPA approach in mind. Therefore, an in-depth, yet flexible discussion has been created. This has provided an insight into the experiences and perceptions of participants.

**Materials**

A consent form was given to the participant (see Appendix 1), outlining the details of the study. The consent form explained how the interview would be recorded. It also explained the participant’s right to withdraw from the study or to withdraw their data at any point.

An interview schedule consisting of twelve semi-structured questions was used to guide the discussion between the researcher and the participant (see appendix 2). The interview questions were devised using the values of the IPA approach. A Dictaphone was utilised to provide an audio recording of the interview.

**Participants**

Since interviews have been used to collect the data, just six participants have been necessary; this is because of the detailed nature of qualitative methods, particularly interviews which involve personal communication with the participants.

Participants of the present study consist of six practitioners; a music therapist, a sound therapist, three ‘music for health’ practitioners and a participant who is both a trained
music therapist and ‘music for health’ project manager. This variety of music practitioners allowed the research question of how different musical interventions work, to be addressed. Therefore, purposive sampling has been used to ensure that each participant has these necessary qualities. Patton (1990) contends that qualitative research should employ purposive sampling to suit the study. These participants were recruited using personal invitations, distributed via e-mails or phone calls.

**Data collection**
A semi-structured interview schedule has been used to gather data and guide the discussion. Chapman and Smith (2002) suggest that this type of interview is most suited for the IPA approach, since it allows deep analysis but maintains a flexible nature. Questions are open-ended and non-directive so that they provide an opportunity for the participant to share their personal experiences (Willig, 2002).

Interviews were recorded and transcribed verbatim. Following this, individual transcripts were read and reread in order to allow for a thorough understanding of the text. Bensimon et al. (2008) used this technique of multiple observations (Dey, 1993) to become familiar with musical and verbal content of interview transcripts.

**Analytic Process**
Brief character vignettes were written to build an affinity with the participants and to provide the participants with pseudonyms to protect their identity.

Notes were made with each analysis of the transcript, and themes were then created as a result of the features that were initially identified. This procedure was put into practice by O'Callaghan (2011) who found evidence that music helps children through the damaging experiences of being diagnosed with and dealing with cancer. Connections were then made between themes to create a clear explanation of each case.

The next stage of analysis involved the creation of a summary table of structured themes. Quotations from the interview transcripts were added to support each theme. A group label was given, and within each group separate themes were created, with brief quotations and references. The summary tables for each participant were integrated into a comprehensive list of main themes that reflect the experiences of the group of participants as a whole (see Appendix 4). These main themes were checked against the transcripts to ensure they were grounded in the data.

From these more general themes that apply to the group of participants, a connection was made to the original themes and notes were made to the extracts. All themes were described and their diverse expressions from different participants have been explained. In order to demonstrate the use of these themes, quotations have been given along with links between themes to illustrate the participants' experiences. Appendix 4 displays a hierarchy of themes, which facilitated the production of the final model proposed in this study.
Results
The following commentary outlines the findings of the study. Emerging themes from the data are outlined, using quotations from interview transcripts. All interview recordings were transcribed verbatim by the researcher, which enabled full engagement with the data.

Themes
The themes have been organised in two ways. Connection and adaptation are the two dynamics at work here. Within these are three stages which all participants illuminated. These stages consist of ‘anticipations’, ‘interactions’ and ‘alterations’.

Anticipations
The first theme which constitutes the relationship between the practitioner and the patient is ‘anticipations’. ‘Anticipations’ refer to any initial thought, state of mind, or preparation involved in the musical therapeutic relationship. All participants referred to an initial level of awareness and receptivity required before they begin a session with a patient. Along with this, expectations of the practitioner and the patient are key to the commencement of therapeutic interaction.

Sensitivity
All practitioners referred to the need to be sensitive to the needs of the patient and the environment they are working in. Elise spoke about sensitivity when dealing with patients, emphasising how it is important to take the patient’s issues seriously.

“Just be really gentle, and, just seriousness if you like, I mean everything is serious to everyone when they’re there” (Elise, 271-280)

This instantly suggests how an awareness of the patient’s needs is essential from the onset, taking on board the views and feelings of the patient in order to create a basis for a therapeutic process. Being “gentle” hints at the gradual pace of the relationship, focusing upon the patient as opposed to the practitioner. This step away from using music intrusively is also described by Miranda:

“So it’s being incredibly sensitive and incredibly attuned and not going in with all your noise” (Miranda, line 177)

There is a real sense of adjusting to the environment and the patient here. Being able to blend in as well as possible with a given situation allows for a unique session, shaped to suit the patient. Since a hospital environment is the context for Music Therapy and music for health practice, practitioners must be sensitive to other people and procedures.

“Inviting people to come and do something unfamiliar…may be a bit daunting, when they are sick” (Julia, 53)
“Respond musically to whatever the client is able to do” (Dr. Bannister, 26-29)

Again, it is clear that the need to empathise and be intuitive when dealing with a patient is resonant in the use of musical interventions. The abilities and level of involvement the patient wishes to exert must be ‘nurtured’ (Elise, 10). This has an association with the subtheme of ‘involvement’, which is involved in the ‘interaction’ stage of the therapeutic relationship.

**Expectations**

This refers to both expectations of the practitioner and the client. Music Therapy has specific aims and therefore it is important for the patient and the practitioner to have a common understanding of what is expected from the session.

“it is important to be sure…what they, or the people who have referred them, think they're going to get out of Music Therapy” (Dr. Bannister, 26-27)

Whereas, the music for health approach and Sound Therapy are less structured and revolve around having no aims or expectations.

“That blank canvas thing…I'm not looking for anything from anybody” (Elise, 186)

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“Real kind of spark, when he realised, actually, I've got some say here” (Jeremy, 161)

Here it is evident that the expectations of a patient also shape how the musical interaction will be received initially. Any preconceptions they have may cause resistance initially, yet when they realise they can take control, this resistance often subsides. Additionally, absence of expectations from the practitioner allows the patient to shape the session and be themselves.

**Interactions**

**Human interaction**

The process of the patient and the practitioner interacting can be therapeutic in a number of ways; firstly the core contact with another individual allows the patient to feel a connection.

“It’s like ‘oh my god finally someone who’s going to listen’” (Elise, 189)

Here, the element of human interaction is important for Elise’s patients, allowing them the opportunity to offload their issues onto her. Although her Sound Therapy practice is the only discipline that incorporates talking about issues, the other participants also addressed the importance of human contact for their patients.

“A social, human, outcome” (Julia, 245)
“Isn’t about how good their blood pressure is today…it is actually a human connection” (Jeremy, 181-182)

**Non-verbal communication**

The use of music as a medium for communication represents the core of musical interventions. All participants advocate the use of music as a connection between them and their patients.

“You don’t need words, it’s just about again, finding that place…together.” (Jane, 24-25)

“Music is almost a tool for that human connection” (Jeremy, 95)

“It’s the same kind of human contact, but, for me works on a deeper, emotional level, to really support somebody.” (Jeremy, 76-77)

Here, it is clear how music provides a mode of connection for the participants, on a different level to that of the verbal language that humans are saturated with in everyday life. This new wavelength of human communication provides a unique connection which can be interpreted however the patient wishes and eliminates issues for patients who are non-verbal, suffering pain, or who have a tendency to shyness.

**Expression**

Interaction allows things to be communicated; the use of music enables expression that words cannot fulfil. Linked to the concept of non-verbal communication, expression allows emotions to be dealt with.

“From peace, friendship, rage…musical violence even, but in the music it can be contained, music is a broad enough world to encompass any emotional reaction.” (Dr. Bannister, 71-72)

The vast array of emotions dealt with in Dr. Bannister’s experience displays the unique nature of Music Therapy, in that it utilises whatever the patient brings to the session.

“The best music I think comes from the emotions of a person, from the soul if you like, rather than just a technical ability to make sound” (Jeremy, 83-84).

“It’s hard not to get teary as well. But I think it’s really important to allow that to happen because it’s really natural, it’s really part of it. You go and you have a good old cry and you go back in and you do it again. Because you know, it’s a lovely thing to do.” (Jane, 131-133)

The emotions involved from the perspective of the practitioner are evident here. Expressing feelings is key for both parties of the therapeutic relationship and facilitates the connection between them.
**Shared experience**

The connection established from the music allows the interaction to develop into an experience which can take many forms.

“A little journey that goes back and forth...you’re sharing something...there’s trust.” (Elise, line 138).

The shared experience between the practitioner and the patient is crucial to assist the musical process.

**Alterations**

Following the initial anticipation and consequent interaction, comes an alteration of some sort. This was evident in all participants' experiences and can take many forms.

**Concept of time and space**

Alterations in one's perception of time and space were discussed with an emphasis on being 'present' in the moment with the client.

“Everything goes out of the window and you're just totally in the moment and focused on that person and trying to...meet together. Somehow. For me, it’s almost like meditation sometimes” (Jane, 124-127)

Practitioners’ focus upon their work can clearly impact their perception of time. Also, time is an important issue for the patient. Jeremy describes patients’ lives as being subject to a “slow rota” (line 138) music enables an alteration to this predictable routine; accordingly, an escape from the situation is created.

“They want to lose themselves in the music” (Elise, 255).

“Fun and enjoyment...very different from the rest of life in the hospital” (Jane, 66)

**Roles**

Participants explained how music has changed the demeanour of staff to be more amiable and less clinical. The role of the patient was also identified as altered from their usual label within their family to an honest role of how they wish to present themselves.

“Oh just to see this guy who was doing something clinical...almost change his stance to being like a father figure and to start singing to the baby.” (Jeremy, 248-251)

**Self-perception**

All participants referred to patients' self-perception altering in some way, separating themselves from their condition or pathology. This led onto independence since the musical interactions were found to provide the patient with a coping mechanism they can use themselves.
“It’s a great connection for that child, back to something that is the healthy child” (Jeremy, 227)

“Helping people see how they can do everything for themselves...that whole position... ‘Be your own healer...physician heal thyself’.” (Elise, 170-173)

“It helps your resilience, because it’s something you can do on your own” (Miranda, 135)

**Observable outcomes**

All participants described alterations as a result of their work in the form of more observable outcomes. This included physical and psychological responses.

“His figures and oxygen...his blood and respiration rates...were actually described as better. It was the best she’d seen during the day.” (Jeremy, line 193-195)

Here, there are clearly clinical outcomes regardless of whether there are clinical aims to the musical approach. Similarly, when there are specific aims, more general outcomes can be evident.

“Use music to help them discover energy...vibrancy...” (Dr. Bannister, 118-119)

Therefore, observable alterations are also evident and wide-ranging for all participants.

**Reflection**

Evaluative issues were explored by all participants, explaining further the importance of being flexible and adapting to a given situation.

“It’s negotiated all the time...you can’t take anything for granted” (Jane, 153)

The nature of musical interventions was brought to light with reference to difficulties proving its impact.

“Music has been proven to be better value for money than what the health service can provide. Which is fantastic...I think all we can do realistically is to take what people say about how they feel and what impact it has had on them...usually, that’s a very honest, open reflection of the impact it’s had on them. What we need to try and do is to make quite a broad study on that. So that...it’s perhaps more...scientific...It’s very difficult. Sometimes the hardest thing to do is to...is to leave somebody. Quite often we’ll try and leave music with somebody. So, we’ll leave a space still playing music, which you can probably imagine actually, almost leaves music with that person....So, to stop the music and give someone a questionnaire to ask how they’re feeling is a horrible thing to have to do.” (Jeremy, 281-292).
There are the following subordinate themes under each stage.

**Anticipations**
- Sensitivity
- Expectations

**Interactions**
- Human interaction
- Non-verbal communication
- Shared experience
- Expression
- Level of involvement

**Iterations**
- Self-perception
- Perception of time and space
- Measurable outcomes
- Roles
- Reflection

All participants explored sensitivities and expectations, as a prerequisite to initiating the therapeutic relationship. Once these anticipations were addressed, the level of involvement offered by the patient was identified as essential for initiating the subsequent response from the practitioner; thus, interaction commences. This interaction was defined by participants in many forms, initially by the power of a simple human interaction, which then progressed to a non-verbal form of interaction allowing both the participant and their patient to express themselves. These interactions constitute a shared experience for both parties, enabling the subsequent alterations. These alterations also manifested themselves in a variety of forms. Participants described the observable impact of their practice upon individual patients in terms of psychological and physical wellbeing. Music also emanated an altered sense of time for both parties, along with changing the roles of those it surrounded. This in turn created an escape from the current situation and thus the participants recognised an alteration in patient’s self-perception. As a consequence of these themes, reflection upon the therapeutic process was identified as essential to shape future practice. Hence, another alteration is evident.
Discussion

“All of us have had the experience of being transported by the sheer beauty of music...suddenly feeling a sense of the sublime, or a great stillness within...” (Sacks, 2006).

Music's ability to alter one’s perception of space and time is conveyed here by Sacks (2006). The present study’s findings are concurrent with this, with participants describing how musical interventions can change the perception of an environment, thus transporting themselves and their patients to a better place. Research by Preti and Welch, (2011) is also supported by this, since they found musical interventions to act as a sedative for paediatric patients undergoing clinical procedures, indicating a less threatening environment as a result of music. Lazarus’ (1991) transactional stress theory is also substantiated here. His idea that stress depends upon the meaning of a stimulus to the perceiver comes into play. Participants of the present study stated how patients’ altered view of their situation created a more positive outlook. Here, it seems clear that music can change the meaning of a stressor to the individual perceiving it. This is just one constituent within the main theme of ‘alterations’ identified as a result of musical interventions. This situational escape described, provides a coping mechanism, implicating independence and thus connects with the following subtheme of an altered self-perception.

Altered self-perception was another dimension of ‘alterations’. Participants explained how their patients gained a new identity through the use of music as their confidence in their own abilities grew. It follows that participants described patients as empowered to exist in a different way without being associated with their condition or pathology; interpreted as a ‘musical being’. Winnicott’s (1971) theory of transitional phenomena upholds the view that music allows one to exist differently and thus the present study corroborates this. The work of Lamont (2002) suggests music’s impact upon one’s identity, which is also supported here. In order to provide a more accurate account of how patients perceive their identity through music, more research should include the perspective of the patient. Another association with this altered self-perception, is the perception of others which was found to alter through musical interventions.

Also essential within this theme, are the observable alterations participants reported in their patients. These included improved heart rate, blood pressure and reduced pain. Alongside this came enhanced relaxation, enjoyment and wellbeing. This supports the array of research displaying the multitude of benefits of musical interventions (Erkkila et al., 2011; Jones & Van de Eerden, 2008; Kusatz et al., 2005; Letts et al., 2011; O’Callaghan, 2011; Sherratt et al., 2004). Methodological flaws exist in the current research (Sen et al. 2011) which are eliminated in the present study since blinding is not required. Such methodological issues create difficulties in evaluating musical interventions which is explored in the following theme.

All participants divulged the importance of engaging in ‘reflective practice’, involving evaluating and learning from their experiences. Silverman (2010) stressed the need for more randomised controlled trials in the domain of Music Therapy, thus highlighting the
need for more evidence. The present study does not fulfil this demand for randomised controlled trials, suggesting the need for more quantitative research alongside qualitative research. Evidence demonstrates the pitfalls of randomised controlled trials for musical intervention research (Denora, 2006; Sen et al. 2011). It follows that participants in the present study expressed the need for a different type of evidence to be accepted, thus supporting the criticisms of Denora (2006) and Sen et al. (2011) whilst advocating the need for more evidence through reflecting upon their own work. Participants’ reflection upon their therapeutic relationship relates to the ‘interactions’, which are required to produce these aforementioned alterations.

Interaction was found to take many forms and to be vital to the progression of the therapeutic experience. This supports Bruscia (1998) who places emphasis on the importance of the relationships that grow as a result of musical experience. Firstly, non-verbal interaction through the medium of the music was found to be dominant. Participants referred to the use of non-verbal communication as a deeper way of connecting with their patients. The way that the human brain processes music is opposed to that of language (Koelsch & Siebel, 2005) and since everyday life is saturated with verbal language, this new wavelength of interaction creates a distinctive possibility for connection. This facilitates a shared experience between the practitioner and the patient.

The experience shared between the practitioner and the patient constitutes a core aspect of the interactions in the present study. This experience was often referred to by participants as a “journey”, implying the interconnectivity of both parties, similar to O’Callaghan’s (2011) analogy of a ‘human musical mirror’ to explain the therapeutic relationship. This links with the previous theme of self-perception, since the shared experience of interaction enables altered self-expression. Here, both parties can coexist in a manner not dependent upon language, which supports Gold et al.’s (2007) emphasis on building and sustaining therapeutic relationships within musical interventions. The importance of human interaction is involved here, which was identified as a key feature of participants’ experiences.

Human interaction was found in the present study to be essential, emphasising patients’ need to be understood by another human. Many studies have found communication to be improved by music (Groß et al., 2010; Mandel et al., 2007; O’Callaghan, 2011; Schmid & Ostermann, 2010) and the present study found communication with the practitioner to be a precursor to this improved communication. The ability to express oneself without the usual trepidation caused by clinical interactions becomes relevant again here, since participants spoke about how changed self-perception was a result of this human interaction. The following theme of anticipations makes this interaction possible.

Initially within the theme of anticipations was the importance of sensitivity. Participants expressed the need to be sensitive to the patient and the situation. This creates a common ground which all participants addressed as crucial in dealing with their patients. This displays how the practitioner requires the ability to read the patient’s needs and what is appropriate for them in the given situation. This supports research highlighting the need
for a trusting relationship between the practitioner and the patient. (Intven, 2010; Langston & Barrett, 2008) This initial theme also fulfils the suggestion of O’Callaghan et al. (2011) to focus upon the ‘therapist effect’ and determine the qualities needed for effective practice. This awareness is required to initiate the musical intervention and is accompanied by initial expectations of both the practitioner and the patient.

Expectations were found to shape the musical process. Expectations of the practitioner were found to differ depending on the approach used. Music Therapy practice was found in the present study to revolve around specific expectations, which stemmed from an agreed aim, supporting Abrams’ (2011) association of Music Therapy with biomedical aims. The music for health framework and Sound Therapy were found to have no expectations and provide a ‘blank canvas’ for the patient. The key inconsistency between the musical interventions lies here. The patients’ expectations were also found to shape the process of musical intervention. Participants explained how patients do not expect to be in control of the musical intervention since they are often subject to clinical procedures. This was found to create resistance initially, yet when the patient realised they can have an input, this changes and the process between the practitioner and the patient progresses. Accordingly, the importance of expectations and an equal relationship between the practitioner and the patient is emphasised (Intven, 2010).

This study has identified a cyclic model of anticipations, interactions and succeeding alterations. (A.I.A). This process consists of two key dynamics: ‘Connection’ between the practitioner and the patient and ‘adaptation’. Despite Music Therapy’s aims, all three disciplines adhere to this model. The model advocates an explicit disavowal of the medical model and its linear, curative outlook. Instead of a traditional doctor-patient relationship, an alternative model is suggested. Within this, a reciprocal, communicative relationship develops with the patient. Rather than the top-down communication of the medical model, this model involves a two-way process which is based on reflective practice.

There are slight differences in the priorities of practitioners and their disciplines, which alter this model. Depending on the practitioner’s focus, the emphasis of different aspects of the process differs. This also depends on what the patient brings to the session, thus demonstrating the relational nature of the process. The strata of musical interventions analysed in the present study do however share a similar skillset and underlying philosophy pinpointed by the A.I.A. model. This maintains the idea that musical disciplines are related on a continuum (Crowe & Scovel, 1996; Hilliard, 2006). Daveson et al.’s (2008) advocacy of an indigenous Music Therapy theory is expanded here to provide an indigenous theory for a variety of musical interventions.

**Limitations**

The present study does have issues inhibiting its validity. The perspective of the practitioner cannot be assumed to accurately represent the views of their patients; therefore, further research incorporating the views of both patients and practitioners would be beneficial. Although the IPA approach attempts to understand participants’ experiences as authentically as possible, allowances must be made for the researcher’s interpretations to impact upon the results of this study. In order to develop a more thorough evaluation of
musical interventions, a mixed method of both quantitative and qualitative research should be carried out. Additionally, the findings of this study cannot necessarily be generalised, however they should demonstrate knowledge concerning the disciplines analysed and form a basis for further research.

**Figure 1:** The 3-stage Anticipations Interactions and Alterations (AIA) model. Whereby ‘connection’ and ‘adaptation’ are the overarching dynamics surrounding the practitioner and the patient and anticipations, interactions and alterations are the developing processes between the two parties.

**Reflexivity**

In order to allow for a full immersion in the field, the researcher visited two hospitals to observe the ‘Music for Health’ approach in practice. The skill of judging a patient's willingness stood out on both occasions, further emphasising the importance of the sensitivity outlined in the initial theme. This experience provided the researcher with certain emotional investments in the field which may impact upon the interpretation of data.

Music Therapy links with biomedical disciplines due to its use of aims, yet this link is not fixed since a parallel theory has been found in the present study. This, along with the holistic stance of Sound Therapy and ‘Music for Health’ shape the conditions described by participants.

The researcher's interpretation of participants' accounts may create an inexact representation of the therapeutic processes identified. Although an authentic understanding of participants' experiences has been attempted, this can never be guaranteed. It follows that the researcher may assume participants' specific accounts to mean a certain thing that may not be an accurate portrayal of the participants' views.
The research method employed in this study was suitable, since Daveson et al. (2008) put forward the notion that analysing the lived experiences of music therapists can create “indigenous Music Therapy theory”, whereby findings contribute towards describing Music Therapy phenomena and enables generalisation of these conclusions. This demonstrates how IPA is of great use here, since this method analyses the lived experiences of participants. Lee (2011) supports this further, emphasising how qualitative methods draw out otherwise hidden matters. IPA allows experience to be focused upon rather than objectivity, yet how accurate the researcher’s interpretation of the participants’ experience is, cannot be certain.
References


