SHORT-TERM MUSIC THERAPY WITHIN A
CHILD AND ADOLESCENT MENTAL HEALTH SERVICE:
A DESCRIPTION OF A DEVELOPING SERVICE

By CLAIRE MOLYNEUX

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This dissertation will present the development of the music therapy service at Tanglewood, Children’s Day Resource, Leicestershire Child and Adolescent Mental Health Service (CAMHS). An account of the range of treatment offered at Tanglewood and the role of the music therapist is given. This is followed by a literature review that explores literature related to short-term approaches to therapy. These include short-term psychodynamic psychotherapy, short-term treatment approaches with children and their families and short-term music therapy.

The development of the author’s approach to short-term music therapy will be described and case studies will be used to illustrate the therapeutic aims and outcomes of this approach. The case studies will include assessment and short-term work with individuals and families.

Finally, the dissertation will clarify the general features of a short-term model of music therapy as emerged from clinical practice. Some suggestions will be given as to why this model seems appropriate in the CAMHS.
Chapter One

Tanglewood and the Role of the Music Therapist

This chapter will begin with a general introduction to the dissertation. I will then describe Tanglewood and the service it offers to the Child and Adolescent Mental Health Service (CAMHS). I will give an overview of the music therapy post and how this functions as part of the multi-disciplinary team. The chapter will end with a description of the various assessment and treatment packages that are facilitated by the staff at Tanglewood.

1.1 Introduction

Music therapy in Great Britain has traditionally been viewed by both music therapists and other professionals as a long-term treatment approach. The Association of Professional Music Therapists (APMT) defines music therapy as:

‘…a framework in which a mutual relationship is set up between client and therapist. The growing relationship enables change to occur, both in the conditions of the client and in the form that the therapy takes…’ (APMT, 1990)

This definition suggests a long-term approach as the ‘growing relationship’ is the tool of change. A ‘relationship’ between client and therapist would appear to be based on time spent together, knowledge and the rapport that develops between people.
This long term approach to music therapy may have stemmed from the tradition of music therapists working in large institutions and special education. Leslie Bunt (1994) outlines the development of music therapy and states that people with long term problems ‘such as profound physical and mental disabilities or chronic schizophrenia’ were often referred to music therapists. Thus, work with this client group was often long-term by its very nature, as these were long-stay patients. In my experience as music therapist in the Leicestershire Child and Adolescent Mental Health Service (CAMHS) and in Special Schools in Leicestershire there are different approaches and assumptions made about the duration and model of work a therapist might adopt. In Special Education for example, a child may receive music therapy for many years, with the approach being developmental and psychodynamic. In Child and Adolescent Mental Health Services, the music therapist may provide an alternative approach to treatment, working non-verbally with families and individuals in a psychodynamic framework. As with play therapy, the expectation may be that the treatment will be long-term.

When considering the question of long and short-term approaches to music therapy, it is interesting that Juliette Alvin first became interested in the power of music to express and communicate in the group setting of a concert. Her book ‘Music Therapy’ (Alvin, 1991) includes a detailed description of a concert given in a psychiatric residential home for
adolescent boys. Alvin states that the boys showed ‘attention, interest and enthusiasm’ throughout the concerts and that:

‘A few days after the performance a number of boys asked the psychiatrist in charge if they could form a music club in the home. This very unexpected request was a proof that the musical experience had answered an emotional need, and that a music group could help them towards creative and constructive activities.’

Alvin goes on to state that ‘music therapy is usually a long-term process which can be understood only by following every step of the treatment.’ In the case study that follows this statement she describes working closely with a psychotherapist who found that ‘music therapy sessions immediately prior to psychotherapy sessions facilitated the emergence of repressed unconscious material which was of much psychotherapeutic value.’ This clearly links music therapy with psychotherapy which is traditionally a long-term treatment.

It would appear that as music therapy emerged as a profession in Great Britain, it allied itself strongly with verbal treatments such as psychotherapy. Bunt (1994) discusses the relationship of music therapy to a variety of other treatments and reflects on the possibility for music therapy to ‘step outside existing frameworks and orientations, to establish itself as a unique discipline’. Now recognised as a credible profession and state-registered, the debate among music therapists seems to currently centre around the efficacy of different models of working. Bunt (2000) suggests striving for ‘multiple truths and a multiplicity of forms’.

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This dissertation will focus on the establishment of a music therapy service at Tanglewood, Children’s Day Resource within the Leicestershire CAMHS, looking particularly at a model of short-term music therapy. This approach has developed from clinical practice. I will begin with an overview of Tanglewood, the music therapy post and the treatment packages that Tanglewood staff facilitate.

Chapter Two reviews literature regarding music therapy diagnostic assessment, short-term psychotherapy with adults, short-term approaches with children and their families and short-term music therapy. This chapter ends with an attempt to define the general features of short-term music therapy.

Chapter Three describes the development of my approach as a music therapist and examines the effect of the short-term and temporary basis on which I have been employed at Tanglewood. Chapters Four, Five and Six present case studies of music therapy diagnostic assessment and short-term individual and family work that I have carried out at Tanglewood.* The music therapy group described in Chapter One is more long-term and the approach is therefore different to that used in individual and family sessions. Thus, no case studies have been included, as analysis of the group is beyond the scope of this dissertation.

* For reasons of confidentiality, names and some details have been changed in the case studies.
Chapter Seven will attempt to draw together and reflect upon the case material presented. The model and approach to short-term music therapy that has emerged from clinical practice will be clarified. I will also examine why this model seems appropriate in the Child and Adolescent Mental Health Service.

1.2 Tanglewood

Tanglewood became operational in June 1993 providing a children’s day resource to the Leicestershire Child and Adolescent Mental Health Service (CAMHS). Tanglewood provides a service that is distinctly different to that offered by the out-patient service. Children aged eleven and under attend for both brief focused pieces of work and longer term therapy. Due to the multi-disciplinary team and broad range of skills available, Tanglewood is able to offer a variety of group work including social skills, music therapy, a psychotherapeutic play group and family days where several families attend the unit once weekly for six weeks. Recent developments have also included a treatment group for children with Attention Deficit Hyperactivity Disorder (ADHD).

The multi-disciplinary team consists of a consultant child psychiatrist, a senior registrar, clinical psychologists, occupational therapists, nurses, a music therapist, administration and secretarial support and a cook. This means that the unit has a wide range of skills upon which to draw. These include an eclectic mix of systemic, behaviouralist and psychodynamic
approaches as well as assessment of parenting and behaviour management strategies.

Tanglewood is a tier three or tertiary service. This means that referrals come from the out-patient teams and Primary Mental Health Workers (tier two) within the CAMHS. The out-patient teams receive their referrals from the tier one services such as General Practitioners, Social Services and Health Visitors.

Tanglewood offers a unique opportunity to assess some children and their families in more depth than is possible on an out-patient basis. Ingrid Davison Consultant in Child and Adolescent Psychiatry at Tanglewood points out that increased understanding of the family’s problems and their child’s needs can provide insights that are useful in further out-patient work or in formulating an individual programme at Tanglewood (Davison, 1996). Some children therefore will continue with out-patient work and others attend Tanglewood for on-going treatment. Here are two brief case examples of the treatment that Tanglewood might provide:

The Hill Family were referred by the out-patient team for further assessment and behaviour management work. The family consisted of a single-parent mother and her seven children. A programme was devised that ran for four days over the summer holidays. The programme offered the opportunity for assessment of family dynamics and a re-evaluation of the presenting problems. Behaviour management work and other
supportive therapeutic interventions also took place. At the end of the programme, the family were offered a series of follow-up sessions at Tanglewood followed by review with the out-patient worker.

As a contrast to this, the Brown Family were referred for a three day family assessment. Following assessment, the parents were given positive feedback that their behaviour management strategies were effective and consistent. The Tanglewood team felt that the parents were managing three children well, particularly taking into account the attention and behavioural difficulties of the youngest boy. As a result of the assessment, it was suggested that the family seek advice from a paediatrician for the youngest child and a referral was made. The family were offered follow-up work by the out-patient worker, but cancelled their appointments saying that they felt happier with the situation and would contact the service if they needed further support.

As these vignettes illustrate, Tanglewood combines an effective therapeutic approach with flexibility. This seems to be a successful way of building a rapport and working with families to ease some of their difficulties.

See Appendix 1 for Tanglewood leaflet.
1.3 Music Therapy Post at Tanglewood

Following qualification as a music therapist in summer 1996, I was looking for work. Having completed an eight-week placement with Amelia Oldfield at The Croft Children’s Unit, I was interested in finding work in a similar setting and so approached the Head Occupational Therapist at Leicestershire CAMHS. He was keen to explore the possibility of a music therapy input and a temporary six month post was advertised.

I began in post in November 1996. The post was established within Tanglewood rather than on an out-patient team as it was felt that Tanglewood could make best use of the service and had the most appropriate accommodation. In addition, Tanglewood had a history of developing and providing groupwork which suited the introduction of music therapy to the service.

When I first began in post, the work was more generic in nature, as I provided a music therapy input to the existing programmes such as Family Days and Assessment Days (see section 1.4 of this chapter for more detail). This was partly due to the short-term nature of the contract as well as staffing issues at that time. It was also a useful induction period as I found myself adapting music therapy techniques for use in children’s groups that were non-specific. By non-specific, I mean groups that were run as part of a treatment package looking at behaviour management (Family Days). It was of particular interest to the team that musical
activities could afford so much insight into the strengths and needs of the children involved.

As the contract was extended, the opportunity for developing the post presented itself. I took a key role in a pilot project that looked at the efficacy of assessing for Attention Deficit Hyperactivity Disorder (ADHD) and developed a single music therapy diagnostic assessment session that each individual child attended. This resulted in good understanding within the team of the role of music therapy diagnostic assessment and has ensured that it is seen as an important component of the assessment days. The music therapy diagnostic assessment will be described in more detail in Chapter Four.

I have also been able to develop individual work and work with families. This development was well supported by the team and the consultant psychiatrist at Tanglewood who made the initial referrals. As these members of staff are also involved in out-patient work, the possibility of taking referrals from the out-patient teams was explored. I presented some case studies at a training meeting and this helped to generate interest in music therapy. Music therapy now receives a steady flow of referrals from a range of professionals and would appear to be valued within the service. Music therapy diagnostic assessment sessions are frequently observed by trainees from a variety of disciplines which helps to increase awareness of the potential of music therapy.
As part of the multi-disciplinary team, I have the support of colleagues and there are often opportunities for joint working. This has helped to further develop the general understanding of music therapy. Currently the music therapist has input into the assessment and Family Day packages at Tanglewood. A music therapy group runs when possible depending on the nature of referrals and staffing. Individual and family work is also undertaken and referrals are accepted from both Tanglewood and the outpatient teams.

1.4 Treatment packages

Tanglewood offer a number of treatment packages. In order to provide a general understanding of the service and place the music therapy work in a context, I will briefly describe each treatment package offered. More detail regarding the music therapist’s input to assessments will be found in Chapter Four.

i Assessment Days

Tanglewood offer a three day assessment for children whom it has not been possible to assess in the out-patient setting. The children attend in groups of between four and six, once weekly for three weeks. They attend without parents/carers for the first two days and are then joined by one or both parents/carers on the final day. This gives an opportunity to assess the child’s interactions with peers and with their caregivers. Both child and
family are seen in structured and unstructured groups. A structured group is one where a series of planned activities is used. An unstructured group will be one where play equipment is provided and staff take a less directive role. The child also receives individual assessments including an assessment of play and a psychiatric assessment. Additional assessments are also available including: music therapy diagnostic assessment, speech and language, psychometric testing and motor skills assessment. The multi-disciplinary team evaluate each child to ascertain whether additional assessment is required.

See Appendix 2 for Assessment Days programme, information sheet and Aims and Objectives of group and individual sessions.

ii Family Assessment

The family assessment package arose from referrals that were made to assessment days where the team felt it was more appropriate to assess the whole family rather than just the referred child. It became clear that out-patient workers required a similar package to assess whole families (Davison, 1996) and so the family assessment was devised. Some families are referred as part of a child protection investigation by the local Social Services Department, but more often, they are referred for a more detailed understanding of family functioning than has been possible to gain in the out-patient setting.
Families attend Tanglewood for between two and four days and the team devise programmes according to each family’s needs. The programme always includes structured and unstructured sessions. There is a mixture of creative sessions as well as opportunities for the family to discuss their needs and difficulties as individuals and as a group. Families attend for the whole day and lunch and breaks are part of the programme, giving the opportunity to observe the family in a more informal setting. Often the family are observed via video cameras in a play setting without staff present.

See Appendix 3 for Family Assessment programme.

iii Family Days

Davison (1996) describes the development of family days. The approach is that of:

‘focused group work with a nurturing therapeutic milieu in an intensive, short-term intervention with the aim of firstly, enabling parents to manage their children’s behaviour more effectively, and secondly, to help families to have fun together, thereby breaking the vicious circle of negative interaction.’

Up to five families at a time attend Tanglewood once weekly for six consecutive weeks. The day consists of a group meeting at the beginning where introductions are made, goals identified and in subsequent weeks, feedback is given by each family about the previous week. There is a creative activity session for the family groups and then separate children’s and parents’ groups. The parents’ group allows the parents to share
experiences and offer support to each other, whilst the group leaders can offer advice on appropriate behaviour management strategies. The children's group is an opportunity to assess the children using structured and unstructured play activities. The aim is to have fun together and provide a positive group experience. The group leaders may identify particular aspects such as low confidence or self-esteem and plan activities to maximise the therapeutic intervention.

As an example of a children's group, we recently worked with a group of just three boys aged ten and eleven years old. They all had difficulty managing their anger and talked openly about feeling frustrated and angry. As group leaders, we were able to plan the group so that these feelings could be addressed through role-play and musical improvisation.

Each family is assigned a key-worker who meets with the family at the end of the day. Sometimes parents and children are seen separately, sometimes together, depending on the work that is undertaken. The key-worker will try to define specific areas to work on with the family, often taking a behavioural approach. As Davison (1996) states, parents are ‘encouraged to set clear, firm and consistent limits on unacceptable behaviour and to promptly reward desired behaviour.’

See Appendix 4 for Family Days programme and information sheet.
The ADHD Treatment Group was developed to complement the groupwork already taking place at Tanglewood. The group was aimed initially at those children who had attended assessment days and had been given a diagnosis of ADHD. The team felt that some kind of group work should be available to address the social skills, behavioural and attention difficulties that these children experienced. The group would compliment the pharmacological approach traditionally taken to treat ADHD.

The group is facilitated by two members of staff with a third worker running a parents group. The main aim of the group is to assess each child and promote their strengths using creative activities.

The group meets for one and a half hours weekly for between eight and ten weeks. Parents are offered feedback and a report is written. The group facilitators also arrange school visits to discuss the outcome of the group and share any advice regarding managing the child's behaviour constructively.

See Appendix 5 for group information sheet.
As Davison (1996) describes, the Social Skills group was developed to address the large number of children referred to the service with social skills difficulties, often rejected, ignored or victimised by their peer group. The group is facilitated by two members of staff, with a third worker allocated to work fortnightly with the parents. The main aim of the group is to have fun together, with an emphasis on building self-esteem and encouraging the children to adopt a problem solving approach. The age range of children who attend this group is eight to eleven years old.

Prior to the start of the group each child attends an initial assessment meeting where, if appropriate, goals are set. The group then meets for one and a half hours weekly for ten weeks, after which there is a follow-up meeting, evaluation and feedback sessions. The children and their parents are also invited for an informal get-together with cakes to celebrate the end of the group.

See Appendix 6 for Social Skills group information sheet and parents' letter.

The Self Esteem group grew from referrals to the Social Skills group for children aged five to eight years old, a different age group to that usually
accepted for the Social Skills group. The team decided to run a new group. The emphasis is on improving social skills, confidence and esteem through creative activity, positive group experiences and a nurturing environment.

Children attend Tanglewood for five days. They take part in creative activities, games and outings. The group also includes a barbecue and sleepover.

See Appendix 7 for Self Esteem group programme and fact sheet.

Music Therapy Group

The Music Therapy group at Tanglewood was initially planned to run as a slow-open group. This would mean that new referrals could be assessed continually and start with the group at any point. The existing group would be given notice of a new member and similarly, when a member was ready to leave the group, this would be discussed and planned for.

However, due to the way in which the music therapy post has been funded, the group has had to be planned to end before each temporary contract was due for renewal. This is an example of how music therapy provision has been affected by the external factor of short-term contracts. As a result we have been able to run three closed groups each lasting an average of four months. The groups are facilitated by the music therapist
and two co-workers, these have included senior registrars, nurses and an occupational therapist. The referral criteria has been fairly wide to encourage clinicians to refer, with an emphasis on children with communication difficulties. A minimum of six children is required to run the group and the age range is six to nine years old. Occasionally we have accepted children outside the age range if the referral is appropriate and it is felt that the child would fit in with the group.

Individual aims are considered for each child after the first couple of sessions. However, the general aims of the group are:

- To explore interaction and communication with others, focusing particularly on non-verbal communication.
- To explore levels of confidence and self-esteem.
- To offer a positive experience of play using music.

Each session lasts one hour and includes some structured or directed activities and also a time for free improvisation. The feedback from referrers has generally been positive with particular comments on the benefit of a non-verbal treatment group.

See Appendix 8 for Music Therapy group information letter for parents.
Chapter Two
Literature Review

This chapter will introduce some of the literature about short-term music therapy and music therapy diagnostic assessment. Due to the lack of literature regarding short-term music therapy, I widened my literature review to include short-term or focused psychotherapy with adults and short-term approaches with children and families.

I will begin by looking at music therapy diagnostic assessment and then go on to examine the various approaches to short-term therapy. The chapter will end with an attempt to define the general features of short-term music therapy.

2.1 Music therapy diagnostic assessment

In this section, I will focus on music therapy diagnostic assessment and not assessment carried out to determine a client’s suitability for music therapy or to determine therapeutic aims. My own approach to diagnostic assessment at Tanglewood will be discussed in Chapter Four. There is not much literature in this area, in fact only a small proportion of music therapists carry out this work.
Bunt (1994) describes a music therapy assessment session at a child development centre where music therapy has a role in the multi-disciplinary team assessment process. The session is evaluated by the whole team and Bunt includes the observations of the other clinicians. He demonstrates the depth and range of information that can be gained from such an assessment. This is true of the multi-disciplinary approach to assessment at Tanglewood where the clinical discussion focuses on key aspects of the whole assessment process in order to build up a true picture of the child’s pathology. The music therapy assessment session contributes in a unique way by providing a non-verbal form of assessment.

Grant (1995) suggests that the music therapist can make a unique contribution to the assessment and evaluation of developmentally disabled children. The author has devised an assessment instrument to address specific areas: ‘sensorimotor; cognitive, especially in the areas of visual and auditory perceptual skills; communication; and social.’

Bunt and Grant have shown how music therapy can aid evaluation of the child’s current state and also make suggestions regarding the efficacy of music therapy when working with such a client group. However, in both cases, the authors seem to confuse diagnostic assessment with assessment for ongoing music therapy. This is possibly because music therapy diagnostic assessment is still a new concept that is evolving. In fact, Wigram calls for clear methods of assessing and suggests that ‘it would be both possible and desirable to generate assessment criteria that
should be tested and refined by widespread trials.’ (Wigram, 2000) Whilst he acknowledges that there would be differences in style and content between clinical areas, he also suggests that some ‘general markers’ may be found.

Amelia Oldfield is currently undertaking research to investigate how music therapy assessments can help the psychiatric team at The Croft Unit to diagnose children suspected of having pervasive developmental and autistic spectrum disorders (Oldfield, Ph.D in progress). Oldfield’s research study aims to assist in developing and formalising music therapy assessment procedures and will therefore be an important contribution to this evolving area of music therapy practice.

I would like to turn to four articles that cover the area of diagnostic assessment more specifically.

Wigram (1995) describes his use of music therapy assessment to provide some information to support, or not to support, a diagnosis of autism. Wigram lists factors that the therapist must be aware of when assessing the child. The music therapy assessment takes place as part of a multi-disciplinary assessment process. Wigram presents several case studies that illustrate the contribution music therapy can make to the diagnostic process. He also comments on the stance of the music therapist when assessing and how this differs from the development of the therapeutic relationship in ongoing music therapy treatment.
Wigram (1999 and 2000) has written about working towards a standardised model of diagnostic assessment and states that ‘analysis of music is a natural starting point to formulate criteria for systematic assessment.’ (Wigram, 2000) He describes a model for the assessment session that is flexible, incorporating ‘free, undirected, elements of the session with more structured and focused areas.’ (1999) He also sets out his methodology for analysing the musical material using the Improvisation Assessment Profiles (Bruscia, 1987). I was interested in Wigram’s General Conclusion to his chapter ‘Contact in Music’ (1999) where he states that:

‘Flexibility is essential in the music therapist’s skills and adaptability to the clients’ needs, to the situation and to their changing emotional and interactional state, within a broad but well-bounded framework, is an effective model.’

He goes on to state that a combination of a strongly structured framework and a flexible, free style of work has ‘proved effective in diagnostic assessment.’ I have found this to be true of the diagnostic assessment I carry out at Tanglewood.

Oldfield (2000) describes the methodology she has developed during clinical practice at The Croft Children’s Unit. In this paper, Oldfield identifies the rationale for including music therapy in the multi-disciplinary assessment package and then outlines the structure and approach that is used. Oldfield, like Wigram, emphasises the flexibility of approach needed to ‘create the optimum situation and setting to evaluate a child’s strengths and weaknesses.’ (Oldfield, 2000)
It will be seen from the available literature that music therapy assessment clearly offers another viewpoint within a multi-disciplinary team assessment. The input of the music therapist as part of the multi-disciplinary team ensures that the child’s strengths and needs have been evaluated using a variety of approaches. The Tanglewood assessment process that will be described later, shows how the multi-disciplinary team aims to assess the functioning of the child in a variety of settings, both within a peer group and with parents. This is essential when making a diagnosis, particularly as a child’s behaviour can be affected by many factors that are external to the presenting pathology.

2.2 Short-term psychotherapy with adults

Although this dissertation is about music therapy with children and their families, I found that some literature on short-term psychotherapy with adults was also relevant. As the following literature shows, short-term adult psychotherapy has been well researched and written about and may provide a starting point from which to consider a short-term approach to music therapy.

Psychotherapy is usually long-term, with the traditional analysis taking several years of intensive therapy, usually five sessions per week. In the 1950’s, however, several practitioners began to explore and write about short-term or brief approaches to psychotherapy (Malan, 1963; Mann, 1973; Davanloo, 1978; Sifneos, 1987) and I will now look at the main
features of this approach. For a detailed account of the development and history of psychoanalysis and psychotherapy, I would refer the reader to “Introduction to Psychotherapy” by Brown and Peddar (1991).

Brown and Peddar (1991) state that while brief or focal therapy may be ‘less extensive than psychoanalysis, it can still be intensive.’ Thus they suggest that brief therapy is a valid approach to treating psychiatric difficulties, not to be dismissed simply because it is ‘less extensive’. This is a relevant point when considering the expectations stated in the introduction to this dissertation that music therapy is a long-term treatment.

Sifneos (1987) describes his approach as ‘a focal, goal-oriented, psychodynamic psychotherapy which envisages that the patient is capable of co-operating with the therapist within the context of a therapeutic alliance and is able to resolve the psychological conflicts underlying his difficulties.’ The central elements therefore would appear to be the identification of goals and a focus on the therapeutic alliance. Brown and Peddar (1991) also comment on the success of brief therapy lying in the intense involvement that is established early on and a strong motivation by client and therapist that is often intensified by an awareness of the time limit.

Butler and Low (1994), offer a useful summary of short-term therapy. They identify general features of this approach, taking into account the variety of literature and methodologies available:
• The therapist is active.

• The psychotherapeutic alliance\(^1\) is a central feature, strengthened by the conscious agreement to focus on an explicit problem.

• The patient’s motivation is affirmed, responded to and developed.

• The focus is on supporting patients in their ordinary lives.

• Containment and structure is provided by the focal issue and the active development of the psychotherapeutic alliance provides a context within which the patient can try out new ways of thinking, feeling and behaving.

I will refer to this later, as I attempt to identify the general features of short-term music therapy at the end of this chapter.

Other practitioners who have given clear methods for practising brief psychotherapy include Strupp and Binder (1985). They write in detail about ‘time-limited dynamic psychotherapy’, giving the reader guidelines to be followed regarding technique, the therapist’s stance, the dynamic focus and other aspects of this type of psychotherapy.

I would like to look now at the issues regarding termination of therapy. Strupp and Binder (1985) make the observation that many therapies conducted by students fail to confront the importance of termination

\(^1\) The therapeutic alliance is defined by Brown and Peddar (1991) as ‘the ordinarily good relationship that any two people need to have in co-operating over some joint task.’ They also cite Greenson (1967) who defined the ‘working alliance’ as ‘the relatively non-neurotic, rational relationship between the patient and the analyst which makes it possible for the patient to work purposefully in the analytic situation.’
'because the relationship is terminated for fortuitous reasons; for example, the trainee’s rotation on a particular service ends…’ The authors go on to discuss the issues around separation and loss for both client and therapist and suggest guidelines for termination. This point is particularly relevant to my experience at Tanglewood, where my short-term contracts frequently dictated the length of therapy available. I was acutely aware, when assessing clients for individual music therapy, of the question, what can be achieved in the time scale available? I hoped to give the ending of the therapeutic relationship the importance it required, despite the external factors. There were times also, where I decided not to begin working with some clients as I felt there was not sufficient time available.

Another author who has examined the problems surrounding termination is Mark O. Aveline (1995). Aveline states that focal (short-term) therapy is not easy for therapists who are accustomed to ‘the flexibility of long-term work…They see the extent of the patient’s problems and worry that there will be no resolution with the focal therapy, only an unearthing of conflicts. They feel guilt over ending and tend to blur termination.’ This links into my experience as a music therapist where the expectation is for long-term intervention. However, I have found it useful at times, to be placed in a position where time is limited. I feel that this has enabled me to trust more in the process involved in the therapy as the ending is firmly in sight and planned. It has also allowed me to see the positive processes of building self esteem and confidence that come from a therapeutic stance that is committed to the work and not frustrated by the restraints imposed
externally. An acceptance by the therapist, of the limitations on therapy is much more productive than resistance or frustration.

Aveline goes on to explore the idea that therapy is the ‘catalyst’ for change rather than the ‘vehicle’. The word ‘catalyst’ suggests that the therapy leads to action by the client, to effect personal change. Aveline suggests that opportunities for change present themselves at the most challenging and crucial moments in therapy. Termination is one such moment and the impact of termination should not be underestimated.

To continue with the theme of termination, Alex Coren (1996) raises the concept of ‘working through,’ suggesting that in brief therapy there is little of this process which he believes begins after the last session. Coren, a psychotherapist, writes from his experience of working in a student counselling service where the brief therapy offered consists of about four sessions only. He believes that the client can internalize the experience of therapy and for a different version of themselves to emerge. He states that brief therapy conveys ‘therapeutic hope, doesn’t pathologize and doesn’t procrastinate in the sense of recognising that life needs to be experienced and not lived in the consulting room…’.

Coren’s opinions parallel my experience of working with James (described in Chapter Six). The process of change and ‘working through’ continued rapidly for James after music therapy had ended. One significant difference is that James and his family continued to be supported by the
consultant who referred him as well as his attendance at the ADHD treatment group. However, it was felt by all clinicians involved, that music therapy had been a significant catalyst for the changes James made.

2.3 Short-term approaches with children and families

I would now like to turn to some of the literature regarding treatment with children and adolescents in psychiatric services. Much of the literature that I looked at emphasises the importance of having a flexible approach and treating children within their social context, i.e. family, school and friends. The literature also stresses the use of non-verbal ways of communicating with children. All of these ideas are central themes in my work at Tanglewood.

O’Brien (1992) in his introduction to ‘Psychotherapies with Children and Adolescents. Adapting the Psychodynamic Process’, comments that parents are continuously involved in the therapy at varying levels and that the child is seen in a social context ‘with all the forces that impinge on him or her as sources of data and potential interactions with the therapist’. This is seen in the work at Tanglewood where working on issues with the parents, be it behaviour management or communication difficulties, is central to working with the child. In fact, it is essential as clinicians to examine the role that the child is placed in by the parents in order to have a clear understanding of the family dynamics and how the child’s presenting pathology fits into this. For example: a child referred for
assessment days with a possible diagnosis of ADHD is settled and works well with a peer group, but is impulsive, distractible and over-active when parents are present. Thus it is essential that the whole picture be assessed before a diagnosis is made.

O'Brien (1992) also comments on the task of communicating with children, stating the importance of interacting age appropriately and using language that the child can understand and respond to. He suggests that the therapist ‘needs to participate more actively and to work harder to gain patients’ trust and to interest them in the work at hand’. This leads onto the use of non-verbal techniques as an appropriate way of engaging and working with children.

It is widely acknowledged that play and creative activities are vital in communicating and learning from children. There is a long tradition of play therapy with children with emotional and behavioural disturbance (Axline, 1969; Lowenfeld, 1979; West, 1992). The use of music therapy as an appropriate treatment in this area is also documented widely (Alvin, 1991; Bruscia, 1991; Heal and Wigram, 1993; Bunt, 1994; Wigram, Saperston and West, 1996). Literature regarding short-term music therapy will be examined later in this chapter.

Anna Freud and Melanie Klein were pioneers in the development of child psychoanalysis and both advocated the use of play in the treatment of children. Reisman (1973) states that Freud and Klein ‘urged the use of
play as a natural medium of communicating with children and as a means for enhancing adult understanding of psychological difficulties in this age group.'

Whilst it must be remembered that Freud and Klein are concerned with long-term psychoanalysis, some relevant points about ending are raised in the literature. The issue of planned termination being interrupted by external circumstances such as the family moving away or the therapist leaving is documented by Sandler, Kennedy and Tyson in ‘The Technique of Child Psychoanalysis. Discussions with Anna Freud’ (1980). The authors give case examples and some criteria for termination. I was particularly interested in the point made by Anna Freud that terminating a child analysis could be gradual. Freud describes a process of gradual separation where the frequency of sessions is reduced over a period of time that is negotiated with therapist, child and parents. She suggests that the child will detach themselves if normal progress has been achieved, much in the same way as they might outgrow their teachers, but also that the analyst can be visited and remembered on certain occasions. There are links with Freud’s observations and the practice at Tanglewood where the therapist might maintain a reduced level of contact with the child and family before ending completely.

Reisman (1973) states that the ending of psychotherapy ‘can be the most exciting and challenging period of the treatment. The setting of the termination date can catalyze the client into action and it may represent
one of the few occasions in the child’s life when his opinions and decisions have had to be considered by his parents.’ The idea of ending being a catalyst for change was also raised in the literature on brief psychotherapy with adults (Aveline, 1995; Coren, 1996) and links into the case studies described in this dissertation.

Barker (1974 and 1995) gives a useful overview of treatment in child psychiatry. He describes a range of treatment measures including psychotherapy, family therapy, inpatient and daypatient treatment. He clarifies the importance of determining goals and defining the outcome or changes sought by the parents; an approach that is similar to that described in the literature regarding short-term psychotherapy with adults. He also concurs with O’Brien’s (1992) statement that the child cannot be treated in isolation. It follows then, that any assessment of outcome and improvement, involves evaluation of the child’s behaviour outside of the treatment room. This is important in the approach at Tanglewood where reports concerning the child’s behaviour are sought from family, school and other agencies that might be involved such as Social Services.

Barker states that the approach adopted by the therapist should reflect the needs of the family, the developmental stage of the child and the desired outcome, thus reiterating the need for the therapist to be flexible. He concludes that the aim of most child psychiatric treatment is to restore the child to normal development.
Daniel Stern’s book ‘The Motherhood Constellation’ (1995) explores parent-infant psychotherapies with young infants (0 to 3 years). Stern describes brief treatment approaches that usually last between three and twelve sessions. His concept of ‘Serial Brief Treatment’ is of particular interest here.

Stern suggests that when enough therapeutic work is accomplished in a short time, there is not much left to do or the motivation is insufficient to continue. If the initial problem is not ‘significantly ameliorated’ in up to ten sessions, then therapy will need to be of much longer duration and the focus will be different. This is true of some cases at Tanglewood where it has been more appropriate to refer the mother for psychotherapy as this was seen as a major factor affecting the relationship with and behaviour of the child.

Although not a traditional approach, Stern argues that serial brief treatments ‘represent the family’s success in finding a temporal format of treatment best adjusted to a psychotherapy that involves a rapidly developing organism (the baby) and system (the family).’ Like O’Brien (1992) and Barker (1995) Stern goes on to describe flexible approaches to treatment, taking into account the specific problems as they arise. At times a family may need an intensive bout of treatment followed by regular meetings every two to three months. Alternatively, the child may need intensive brief therapy while the parents or family are seen only monthly. This approach is borne out in the experience of some families at
Tanglewood who attend an intensive treatment package such as Family Days and then go on to have regular follow-up appointments. During the follow-up, the family might need contact every month or sometimes only every three months. There are also some families who return to Family Days or go on to have more intensive weekly therapy.

When talking about the approach to ‘serial brief treatment’, Stern explores the use of a positive therapeutic alliance and positive transference as processes that are encouraged in this type of work. The therapist ‘adopts a positive regard toward the family and spends relatively more time on its assets and strengths, searching for, identifying, and focusing on the positive aspects of parenting she observes, than on its pathology and deficits.’ He goes on to state that a positive therapeutic alliance makes the serial brief treatment possible as the therapist is carried as a potentially available source of help during the non-treatment phases. It is interesting to note that Butler and Low (1994) also mention the positive therapeutic alliance as being a general feature of brief psychotherapy with adults.

Although Stern is writing about therapy with younger infants, I feel that many of his observations and views have a relevance to the wider field of child and adolescent psychiatry. In particular, Stern is concerned with treating the parent and child together, an approach that is adopted at Tanglewood. His theory of the motherhood constellation, as a particular mental organisation, is also relevant to our work in child and adolescent psychiatry.
mental health where we are involved in supporting and working with mothers. Stern suggests that the nature of the therapeutic alliance is different when working with mothers and that more attention is paid to a positive alliance. This links again to the work at Tanglewood where the team adopts a welcoming and supportive stance at times when it is important to engage and motivate a family. For example, the Grant Family described in Chapter Four of this dissertation had been hostile to the outpatient workers and were described as ‘difficult to engage.’ At Tanglewood, the emphasis was on enabling this family to feel supported, identifying their strengths and creating a positive, non-judgmental environment. This therapeutic stance resulted in greater commitment from the family and an acceptance of the help that was being offered.

The importance of the child being seen in the social context of family, school and community has already been emphasised, as has the importance of working with the whole family at Tanglewood. Davison (1996) summarises the clinical emphasis at Tanglewood as:

‘the utilisation of group processes to develop brief but effective interventions, and to involve the families of referred children closely in the process of change.’

With the emphasis on working with the family clearly identified, I would like to look briefly at literature on Family Therapy. Barker (1995) describes the family therapist as looking ‘at the family system as a whole, in the expectation that when healthier family functioning is established the
individual members’ problems will have resolved, or at least have been alleviated.’

The work of Milton H. Erickson (Haley, 1985 and 1986), Jay Haley (1987) and Salvador Minuchin (1981) describes various techniques for working with families. The central focus is that of a structural and strategic approach where the family is viewed as a total system. The therapist seeks to understand the relationships and the way in which the family functions in order to effect change. Haley (1986) states that the therapist must ‘identify solvable problems, set goals, design interventions to achieve those goals, examine the responses he receives to correct his approach, and ultimately examine the outcome of his therapy to see if it has been effective.’ The idea of setting goals links to the setting of a therapeutic focus in brief psychotherapy as described earlier.

Once again, a positive therapeutic alliance is important as the therapist seeks to find positives in behaviour or destructive relationships, hoping to effect change by re-framing the negative situation as one that identifies an individual’s or family’s strengths. Family therapy therefore, would appear to have ideas in common with other short-term approaches to treatment, not least to short-term music therapy with children and their families.
2.4 Music therapy literature

I would like to turn now to music therapy literature that deals with short-term treatment. I found few references to short-term music therapy as a form of treatment. This led me to look at case studies that might be short in their duration, but not necessarily as a planned approach (Burke, 1991; Ibberson, 1996). I felt there was a difference between work that is presented as short-term, with specific goals and objectives in mind and work that begins as open-ended, but ends up being short. The latter cases may end for therapeutic reasons, or because of external circumstances beyond the therapist’s control. Issues regarding termination have already been discussed in this literature review. (See p24-25: Aveline, 1995; Coren, 1996; Strupp and Binder, 1984; Reisman, 1973)

I would like to mention a number of case studies that present a single session or the first few sessions in treatment, commenting on the intensity of interaction, as I felt this might be relevant to the development of a positive therapeutic alliance that is central to short-term therapy. Claire Flower (1993) describes such a case when her client, Michael makes ‘immediate and spontaneous use of improvisation’ in the first session. Clive Robbins (1993) describes Nicole’s progress in just five sessions as she discovers ‘self-expression…and musical creation with a therapist.’ Ruth Walsh describes ten hours of music therapy in her paper ‘When Having Means Losing’ (1997). Walsh gives details about the development
of the therapeutic relationship and the events that took place during sessions that informed her understanding of the process. This case study presents the beginning of an ongoing piece of work, but clearly, the therapist has been able to formulate clear ideas about the client’s progress in the first few sessions.

Another case study that is of interest is that by Robbins and Robbins (1991) who describe the first four sessions of music therapy with a girl with brain injury, (she received a total of 55 sessions). It is interesting that in these four sessions, the authors consider the ‘major changes’ to have begun to take place. In addition, they state that ‘most of the effects of music therapy became evident in her school and hostel life by the twelfth session.’

These case studies are relevant as they make important references to rapid development of the therapeutic alliance. There also seems to be an awareness of goals or aims, a feature of short-term therapy as described previously.

In my search to find specific references to short-term music therapy, I reviewed the 42 case studies in ‘Case Studies in Music Therapy’ edited by Kenneth Bruscia (1991). This small study clearly shows that most music therapy work is much longer than my work at Tanglewood.
Out of the forty-two case studies, I was able to establish the duration of thirty-five. Of these thirty-five case studies, fourteen ended within twelve months; three of these are accounts of Guided Imagery and Music (Rinker, 1991; Clark, 1991; Bruscia, 1991); one other is a case study of ‘programmed pitch practice’ (Darrow and Cohen, 1991). There are only three cases that are less than six months in duration, Martin, 1991; Allison, 1991 and Burke, 1991. Of these three cases, only one is with a child and therefore relevant to this dissertation.

Kerry Burke (1991) describes ‘six months of music therapy [that] helped four-year-old Adam express his rage and confusion at the death of his father.’ Burke states his goals for this period of music therapy that appears to have begun as open-ended. The sessions ended abruptly when the child stopped attending. Burke felt that inspite of the suddenness and unpreparedness of the ending, Adam had met the therapeutic goals and the piece of work had been successful.

This reminded me of my experience at Tanglewood where children have made dramatic progress and work has ended abruptly. Sometimes, it has been possible to evaluate why progress happened so suddenly. For example: Julia had been referred to music therapy to improve her confidence and low self-esteem. After four sessions during which I felt she was making progress, she changed schools. This move seemed to capitalise on her improved confidence and esteem and enabled her to make new friends. She requested that the sessions end as she was so
busy with her school and social life. Her mother stated that she was a different girl, much happier and more confident, so we agreed on two more sessions to end. Although music therapy might have continued to address important aspects of Julia’s identity, it seemed vital to end on a positive note and encourage the normal development of her life at home and school.

There is one other case study that I would like to mention. Cathy Ibberson (1996) writes about thirteen music therapy sessions with a young girl who was dying. The rapport between client and therapist is clearly evident in this case study. There also seems to be a focus, particularly for the client, Catherine, who is expressing her grief following her sisters death and as Ibberson learns at the end of therapy, preparing for her own death. As with the cases mentioned above, Ibberson seems to be describing a positive therapeutic alliance. Whilst the focus is not explicit between client and therapist, I would like to suggest, given the author’s reflections, that it was clear for the client.

Amelia Oldfield has written about her approach to music therapy at the Croft Children’s Unit. In the article ‘Mummy can play too...’ (Oldfield and Bunce, 2001), Oldfield and Bunce describe two short-term music therapy groups with mothers and young children. The authors state that ‘the therapeutic effects occur because of new insights or changes in attitudes that happen quickly, rather than gradually...’ The emphasis in the music therapy sessions is on the relationship between the parent and child.
Oldfield and Bunce reflect on why music therapy might be successful with this client group. Parents are encouraged to interact spontaneously and there is a clear focus on positive interaction. In reviewing the session on video, parents are encouraged to recognise ‘that there are times when they can enjoy being with their children. This in turn provides a starting point for looking at ways of strengthening or improving their relationship with their children.’ I would like to suggest a parallel here between Oldfield’s approach and the observations of Daniel Stern (1995) on the importance of a positive therapeutic alliance when working with this client group. It would seem that focusing on the assets, strengths and positive aspects of parenting is more likely to result in a favourable therapeutic outcome.

Oldfield seems to address the therapeutic focus both musically and verbally. By encouraging parents to have fun and interact positively with their children in the music therapy session, negative interactions can be re-framed positively. This is then consolidated in the verbal feedback and through viewing the video.

Oldfield has written elsewhere about short-term music therapy with families at The Croft Children’s Unit. (Oldfield, 1993; Oldfield, 1999) Oldfield’s use of short-term interventions is clearly effective in meeting therapeutic aims. Her case studies consistently show improved self-esteem and confidence for both parents (mothers in particular) and children, and an increased understanding of communication and
relationship issues. The importance of having fun and enjoying being and playing together is also emphasised. This enables the family to focus on the positive rather than negative aspects of their relationships and interactions.

Two short case studies of music therapy with families at Tanglewood are presented in Chapter Five of this dissertation. This work has links with Oldfield’s work at The Croft and will explore further the idea of short-term music therapy addressing relationship, communication and attachment difficulties.

2.5 Summary

I would like to draw together the common themes that have emerged from examining the literature and suggest the general features of a short-term approach to music therapy:

- A positive therapeutic alliance.
- The active stance of the therapist to encourage the client to focus on and explore the therapeutic focus. This may be done musically and verbally (see Case Study, James in Chapter Five and Oldfield and Bunce, 2001)
- Containment and structure that is provided by clear boundaries and attention to the therapeutic aims or focus.
I would also like to suggest that music therapy can engage and motivate some clients more effectively than verbal therapy alone. This was certainly true of the Grant Family (see Chapter Four) who found the experience of having fun and joking with staff in the music therapy session a key part of their change in attitude to the service. These aspects of short-term therapy would appear to encourage commitment on behalf of the client and enable the desired change or therapeutic outcome to remain clearly in focus.
Chapter Three

Approach and Orientation

This chapter is concerned with the development of my approach to short-term music therapy at Tanglewood. I will begin by describing my approach and orientation, including my experiences as a newly qualified therapist. I will then look at the effect of short-term contracts on the development of my working practice.

3.1 Approach and Orientation

Whilst training on the MA in Music Therapy at Anglia Polytechnic University, I had the opportunity to do a placement at The Croft Children’s Unit with Amelia Oldfield. I was interested in her approach and enjoyed working with this client group so decided to explore the possibilities of working within the Child and Family Psychiatric Service (the service became CAMHS in 1999) in Leicester when I qualified. I also began work as a freelance music therapist in two special schools.

My development and clinical approach has been influenced by my working conditions. I shall describe these conditions and their effect on my development in more detail in section 3.2 of this chapter. At this point, I will discuss my clinical orientation as a music therapist. I am influenced by psychodynamic, developmental, and client centred approaches.
My work is centred on the development of the relationship between therapist and child that evolves through musical interaction. The process of making music together can provide a structure and sequence as the relationship develops, offering the child a sense of ‘containment’ (Bion, 1962). Within the structure of either free improvisation or a more directed activity, the child can explore communication, interaction and expression freely. I feel it is important to facilitate a supportive and trusting relationship in which the child can begin to explore the themes that have brought him or her to therapy. In a session I will consider the child’s developmental level and at times may use directive activities to engage and work with the child in a developmentally appropriate way.

In music therapy, I believe that the child is offered a therapeutic space. This is a space where the child can feel safe and begin to build a relationship with the therapist. The therapeutic space is maintained by boundaries such as, sessions taking place at the same time and in the same room, as well as involving the child in the process of preparing for breaks and endings and the duration of therapy. My approach to building a relationship with a child in music therapy is influenced by psychodynamic thought. The session is one where I attend fully to the child and am also aware of my own thoughts and feelings in response to the child and our interactions. Given this environment, I believe that the physical actions and expressions, musical or verbal, of the child can lead to insights being gained regarding the child’s emotional state and his or her thoughts and responses to past and present events and relationships.
The therapeutic relationship develops through shared musical interaction. I work in a client-centred way in that I attend to what the child brings to the session. I may be completely non-directive, allowing the child to explore musical interaction in his or her own way, supporting and responding to this exploration musically and at times verbally. However, I may feel that it is necessary to facilitate the child’s use of the therapeutic space by suggesting activities or ways in which the instruments might be explored. In this way, the focus on a more structured activity can enable the child to be more creative and flexible, thereby increasing the opportunity for self-expression and communication. Where I am more directive in a session, my interventions always develop from attention to the needs of the child at that particular time. (This is different to the use of directive and non-directive activities in the music therapy diagnostic assessment where the aim is to create the optimum environment for gaining information about the way in which the child relates and interacts. See Chapter Four.)

Engaging the child in a developmentally appropriate musical activity may engage them sufficiently to allow a relationship to develop or the therapeutic focus to be addressed. Ainscough (1998) suggests that no matter how structured an activity, the relationship between child and therapist continues to be non-directive. ‘It may be that the activity is necessary to anchor the child in the world of reality so that the therapist can bring that special relationship to bear.’ The principle of non-directive
therapeutic intervention however, is maintained and the child is supported in his or her exploration of feelings or experiences.

As well as my approach being informed by psychodynamic, developmental and client-centred approaches, I believe that musical improvisation can embody emotional expression. My response as therapist can act in a similar way to that of the mother to her crying infant, allowing painful feelings to be transformed and worked through in the music. This is seen in the case study of James (Chapter Six) where the music acts as a container through which James can express and process his emotions. My role is to listen and respond musically in a supportive, and at times challenging manner.

3.2 The Effect of Short-term Contracts

I started work at Tanglewood in November 1996. My first contract was for five months and my duties were mainly generic, offering a music therapy input to the programmes already provided at Tanglewood (see Chapter One). During this time, I began to look at the way in which a discreet music therapy service might fit into the CAMHS. When my contract was extended, after four months, I put out a flyer asking for referrals for individual music therapy. I also did a presentation about music therapy to clinicians at a weekly in-service training event. Referrals came in slowly at first and I followed up the training I had done by presenting some case
studies, to demonstrate the sort of client who might benefit from music therapy. As clinicians became more familiar with my work as a music therapist, more referrals were made.

In spite of the fact that many clinicians were supportive of music therapy within the CAMHS, it took four and a half years before a substantive (permanent) post was created. During this time, I was never assured of a position for longer than twelve months at a time; most of my contracts were in fact shorter than this. This position had a profound effect and influence on my work.

My working conditions have raised some interesting questions when assessing for individual or group work. I have been forced to consider how long a piece of work might be and plan a period of assessment accordingly. It has meant that the process of ‘ending’, both in clinical terms and in reality, has been almost continual for me as a music therapist. Evaluation and review therefore, have been a key component of the development of the service at Tanglewood and my development as a music therapist.

As well as being employed at Tanglewood, I was working freelance in two special schools with children aged four to nineteen with profound and multiple learning disabilities, autism and challenging behaviour. The process of assessing, evaluating and reviewing progress that was a vital factor in my work at Tanglewood, also affected my approach at the schools. In contrast to the short-term work at Tanglewood, at the schools,
I was working with some young people who had been receiving individual music therapy for many years. One common theme emerged: the need for me to assess a client’s potential and then be clear about the goals and aims of the music therapy.

It seems relevant that in both workplaces, there was a need for me to evaluate the efficacy of music therapy in order to secure further employment. I feel that this evaluation resulted in rigorous attention paid to reasons for referral to music therapy, assessment of needs and strengths and evaluation of therapeutic aims.

I was also interested in the process of termination, how did I know when to end treatment? As a newly qualified therapist, I knew that termination was important and had to be handled sensitively by the therapist, but I had no experience of assessing when a client was ready to end therapy. During training, all clinical casework was time-limited and was begun with the ending firmly in sight. As a trainee I had wondered about the first long-term cases I would work with and saw this as an exciting prospect. However, in practice, I was faced with having to prove my value as a music therapist working in conditions that were not conducive to open-ended therapy. At Tanglewood I was restricted by the contracts. At the special schools, I found myself questioning the benefits of continual individual music therapy with several different therapists over a period of many years, sometimes more than ten years. This experience has
encouraged me to assess my role as music therapist and look effectively at the needs of clients.

I mentioned earlier (Chapter Two, p24) the observation by Strupp and Binder (1984) that many therapies fail to confront the importance of termination. The following vignette presents my feelings when terminating a period of music therapy that I felt had reached its natural therapeutic end.

Alice was the first referral I received at Tanglewood for individual music therapy. She was a nine-year-old girl with eating problems linked to anxiety. It was agreed that music therapy might increase her confidence and self-esteem, thereby reducing her anxiety and giving her another outlet for control and self-expression. She was referred by the consultant psychiatrist who continued to work with her mother to explore the dynamics of the mother-daughter relationship. The aim of the music therapy sessions was to enable Alice to have fun using a non-verbal medium. My stance as therapist was to be supportive and encouraging, hopefully increasing Alice’s self-esteem and confidence. The natural process of engaging in improvisation would enable us to explore issues of control within the music, thus channelling Alice’s anxiety and need for control in a more constructive way.

After six sessions I met with the consultant to review the case. I reported that Alice had responded well to music therapy and was engaged and
playful. I also noted that she used her whole body when improvising, often
dancing and swaying and felt that this suggested an increase in her body
awareness. I saw this as a positive development as Alice seemed to
express enjoyment when dancing, celebrating her body, rather than
wishing to control or contain it. The consultant discussed her recent
interview with Alice’s mother who stated that what Alice did or did not eat
had become less of a “battle-ground”. She found Alice more relaxed,
confident and playful at home with her younger sister. This was borne out
at school where her teachers felt she was happier.

We both agreed to continue the sessions for another four weeks during
which time Alice continued to improve. I found myself wondering about
the benefits of continuing and after discussion with the consultant, felt that
Alice had in fact made significant progress and that we should consider
ending the sessions. Alice had developed a positive relationship with me
and as a way of helping her manage the ending and separation, I
suggested her mother join us for the last four sessions that took place
fortnightly as a way of ending gradually (see Freud in Sandler et.al 1980).
Another reason for this was to give mother and daughter the opportunity to
have some fun together after the difficult period of managing Alice’s
weight.

I was surprised by the rapid changes that had taken place in three months
and questioned whether ending was the right thing to do. My expectations
as a newly qualified therapist were that therapy would take much longer if
given the chance and that three months was barely enough time to make a thorough assessment. However, I discussed the case in supervision and with the consultant and felt reassured that the progress Alice had made was real and significant. Her behaviour had changed outside the therapy room and her mood was brighter and more relaxed. These were all indicators that she had made progress. In addition, I felt it was important to end the sessions on a positive note and that if therapy were to continue, the focus would be lost and the progress made would become less significant as other factors were brought into the therapy room. The consultant continued to support Alice and her mother following the end of the music therapy. The case was closed some three months later and Alice has not been re-referred.

On reflection, I felt anxious about ending this piece of work in case the changes turned out to be temporary or transient. I was also aware that as this was my first piece of individual music therapy at Tanglewood, the outcome was important as a reflection on the efficacy of music therapy in general.

### 3.3 Reflections

This vignette illustrates some of the factors that affected my development as a newly qualified therapist. I quickly developed an interest in planned short-term work and found this was an appropriate way to work with the client group at Tanglewood. At times, the ending of treatment was
dictated by the ending of my contract. Nevertheless, I always tried to consider the clinical needs of the client and prepare for ending the therapeutic relationship. There were times when it was not appropriate to start treatment following assessment as I knew there would not be sufficient time to engage the client before the end of my current contract.

It will be seen that my working practice has been influenced greatly by the nature of my employment. At the start, this was a frustration to me, however, I now feel that the influence has been positive. I have been forced to take a closer look at the sometimes uncomfortable aspects of terminating therapy. In addition, assessment, planning and evaluation of therapy has underpinned my development as a therapist, leading, I believe to a well defined position within the team at Tanglewood and the wider CAMHS.

This focus on assessment, planning and evaluation has encouraged me to be flexible in my work, attuning to the individual needs of each child. Having a flexible approach enables me to time my interventions appropriately, responding not only to tangible events in the music therapy room but also to affect and my own intuition. The idea of a flexible approach is considered by Wigram (1999) where the therapist provides ‘a variety of musical and interpersonal frameworks with which we can explore our relationship, the client’s needs, the client’s problems, and find the appropriate therapeutic direction.’
I feel it is useful to mention one final point regarding commitment. Whether the therapy is short-term, time-limited therapy or open-ended work, commitment to the approach is vital. Coren (1996) raises this point when he quotes Nina Coltart (1992):

‘Trust in the process, in our technique, in our patients’ and, by definition, in ourselves.’

Wigram (1999) concurs with this when he says:

‘I have found that what is more significant than purely the techniques, materials and structure that goes into making up therapy is how you work through the process and what you yourself bring to the process.’

I have found that accepting and working within the time limit has always been more satisfying as a therapist, even when that time limit has been imposed externally to the therapeutic relationship. The effect of having commitment and belief in the process and my skills as a music therapist must surely have a positive effect on the therapeutic relationship. Having confidence as a therapist relies on many things. For me, my confidence has been enhanced by the focus on assessment and evaluation that has led to a clearer understanding of my role and contribution to the CAMHS as a music therapist.
Chapter Four

Clinical Assessments

This chapter will present my approach to music therapy diagnostic assessment at Tanglewood. I will outline the structure that I use for the assessment session and then describe three case studies. Following this I will describe the type of session I use for a family assessment, again presenting some case study material to illustrate the ideas.

A general description of Assessment Days and Family Assessment at Tanglewood has been given in Chapter One. I would also like to refer the reader to the section on music therapy diagnostic assessment in the literature review in Chapter Two.

4.1 Individual Music Therapy Assessment

Introduction

As stated earlier, Tanglewood provides a three day assessment package for individual children whom it has not been possible to assess in the out-patient setting. The children are referred by clinicians from the out-patient teams. (refer to Chapter One and Appendix 2 for details about the structure of this treatment package.)
At the time of referral, the reason for referral is outlined. This might be as specific as querying whether the child has ADHD or an autistic spectrum disorder. On the other hand, the referrer may ask broader questions about the child’s ability to function among peers or with parents, questions about motor skills and general cognitive ability.

Some of the children who attend assessment days are offered a music therapy assessment session. At the time of referral, the team consider who might benefit from such an assessment. In addition, during the course of the team assessment, other children might be identified as requiring this session. In general, a music therapy assessment is provided for those children for whom it might answer additional questions. These are questions that cannot be answered within the group setting or standard psychiatric or play assessments.

The questions to be answered by the music therapy assessment may include issues around communication and comprehension, understanding and expression of emotional issues and the ability to interact playfully. Often the children who are seen are those that the team feel may gain something from a non-verbal approach to assessment. For example, the psychiatrist may have gained limited information regarding the child’s emotional state or the occupational therapist may have found the child unresponsive to traditional modes of play. In each case, a music therapy assessment offers another means of exploring communication and
interaction with the child that may yield further information, leading to a clearer picture and a more informed assessment.

It is clear from the literature reviewed earlier in Chapter Two, that music therapy diagnostic assessment has a place alongside other forms of assessment. At Tanglewood, it complements the more traditional psychiatric evaluation and questionnaires as well as the occupational therapists’ assessment of play. A single assessment session is available for each child. However, where I feel that I have been unable to assess a child fully in this time, it has been possible to arrange a further session.

When the opportunity to do diagnostic assessment at Tanglewood first presented itself, I looked to my experience on placement at The Croft with Amelia Oldfield and the literature that was available at that time. This was 1996 and not much had been written about this area. I discussed my ideas in supervision with Amelia Oldfield and found Wigram’s paper (Wigram 1995) useful when identifying specific features of the assessment such as:

- Exploring the child’s response to structure
- Exploring the child’s response to a free environment
- Investigating the child’s verbal, vocal and gestural communication skills
- Using music as a means of assessing the child’s sociability, appropriate language, comprehension and interactive skills (Wigram 1995)
My approach in the session was influenced by Oldfield’s work at The Croft, where as a student I had observed and taken part in assessments. This approach is documented in Oldfield’s paper (Oldfield 2000) in ‘Assessment and Evaluation in the Arts Therapies’ (Wigram 2000).

ii Structure of the session

The following is an outline of the structure that I use for the assessment session. It is similar to the structure described by Oldfield (2000). I have found it useful to adopt Oldfield’s use of taking turns to choose what to do next. As Oldfield states:

‘This structure gives the children the freedom to choose and make their own decisions but if the process of choosing is too difficult or painful, the child can relax at the times when I provide him or her with my own choices and perhaps a reassuring structure.’

Oldfield and Wigram have both stressed the need to be flexible in the approach to diagnostic assessment. This is to ensure that the optimum environment is created to assess the child as fully as possible. This is certainly true of the assessments at Tanglewood, where it is important to adapt to each child and structure a session accordingly, depending on the child’s initial response to a particular interaction.
The session always begins in the same way:

- Share bodhran (hand-held drum) to greet each other. I always use the child’s name and say ‘hello’. The child is free to respond as they like, but I might suggest they say ‘hello’ to me if they are reluctant to play.
- Free improvisation with child on standing drum and I play the piano.

Following this beginning, I offer the child a free choice and continue with Oldfiled’s structure of taking turns. From these first interactions, I am able to structure my choices within the session to learn as much as possible about the way in which the child interacts, communicates and relates.

Below are listed some of the elements I may incorporate:

- Sharing bass xylophone. If I want to explore a child’s attention, memory and ability to sequence, I might play a game of imitating simple note patterns on the xylophone. I then encourage this to develop into a freer dialogue to see if the child can be playful.
- Sharing slit drum or other instrument on the floor. I use this particularly when a child has been reluctant to engage or explore the instruments. I want to assess their reaction to proximity when sharing an instrument closely and see whether they can ‘let go’ and interact playfully. I can also challenge a child musically to see if they follow or lead, if this has been unclear in free improvisation where I play the piano.
- Sharing piano. I often suggest this with older children that I assess, particularly when free improvisation has been restrained or tentative. It
is useful to see whether sitting side by side makes a difference to the child’s improvisation. Also, I can initiate playful glissandos or chord crashes to see if the child will imitate and join in.

- Expressive faces played on the drum. I use this game when I want to explore a child’s emotional world more explicitly. By taking turns to make faces for each other to play on the drum, I can assess eye contact, empathy and ability to understand and convey emotions. This is particularly useful when a child has been unable to explore their emotional world verbally in the psychiatric assessment.

- Improvised story. This is a technique used by Oldfield (2000). I find it useful to assess a child’s imagination and whether they can relate imagined events and emotions musically.

- Eye contact or hide and seek games. These can be useful ways to assess a child’s concentration, understanding of rules, playfulness and concept of verbal and non-verbal directions.

The session always ends with sharing a drum together. During a short rhythm exchange, I thank the child for coming and say goodbye. I also use this opportunity to ask what they have enjoyed the most about making music.
Case One - Jeremy

Jeremy is a ten year old boy. The reason for his referral to assessment days was to assess his strengths and weaknesses. He has a higher-level language disorder and dyslexia. There was also a query regarding a possible diagnosis of Asperger’s syndrome.

He attended a music therapy assessment session where the focus was to look particularly at his non-verbal communication skills. Jeremy engaged readily with sharing the bodhran and began to imitate short rhythmic patterns. He showed some imagination in initiating different rhythms. Jeremy played a standing drum while I played the piano and his music was confident and creative. During this, Jeremy listened and responded sensitively, reacting to changes in tempo and dynamics. However, he made no eye contact during our first few interactions.

I suggested we share a slit drum whilst sitting on the floor. I wanted to assess Jeremy’s response to proximity and see if this type of close contact and musical dialogue might elicit some eye contact. He still did not look at me. After about twelve minutes had passed, I asked Jeremy to title a piece we had played together on drum (Jeremy) and maracas (me). He thought for a moment and then looked at me directly and said “The Giant’s Footsteps”. We continued to play, making a story about the giant who chased some people and caught one in his sack. During this
improvisation, Jeremy made appropriate eye contact and his manner was warm and engaging. He went on to choose to play the piano and directed me in our next improvisation. I was impressed by the non-verbal communication skills he used to convey how and when he wanted me to play.

When summarising the music therapy assessment session, I reported that Jeremy had initially avoided eye contact, but this did not continue for the whole session. I felt that when Jeremy had gained confidence in the environment and the medium we were using, he was more able to relate appropriately, including making appropriate eye contact. His musical interactions were sensitive and responsive. He showed good awareness of phrase structure, tempo and dynamic changes. His musicality, coupled with his increased confidence in using the instruments, suggested that he felt comfortable using a non-verbal medium. His use of eye contact, his empathy and responsiveness were not characteristic of a child with Asperger’s syndrome.

In team discussion, it was agreed that Jeremy did not fulfill the criteria for a diagnosis of Asperger’s syndrome. It was felt that his self-esteem was low and this was seen in his avoidance of eye contact, a desire to please and a reluctance to engage for fear of failure. Jeremy had expressed a great deal of anger in the psychiatric evaluation through his drawing of a figure being shot with a machine gun. However, he had been reluctant to explore this verbally. It was interesting and seemed significant that he had
engaged in musical interaction easily. The team felt that a non-verbal approach could enable Jeremy to access and express his emotions as well as work on his low self-esteem. In the final assessment report, the team recommended that some family work was undertaken, exploring Jeremy’s relationship with his mother. In addition to this, it was felt that individual music therapy might be helpful in increasing his self-esteem and giving him the opportunity to express his feelings.

**Case Two - David**

David is a ten year old boy. The reason for referral to assessment days was to consider a possible diagnosis of Asperger’s syndrome. Assessment of social deficits and social phobias, communication and general developmental level was also requested. David presented as a boy who needed routine, lacked imagination and had poor social skills, particularly in the way he related to his peer group.

David attended a music therapy assessment session. He engaged with exploring some musical interaction, using the bodhran and then enjoyed a time of free improvisation on a standing drum while I played the piano. David’s playing was energetic. He was attentive to the musical dialogue between us, he noticed and responded to changes in tempo and dynamics. However, despite some smiles and appropriate eye contact, I felt his playing lacked warmth.
David had chosen to play the piano and gave me a small, wooden frog shaped scraper. David’s playing was loud and exuberant and he used both hands to play large chord clusters. Whilst attempting to support him musically on the frog scraper, I felt small and ineffectual, unable to be heard. David, however, continued to play loudly, paying no attention to me. I wanted to see how he would respond to my musical presence and suggested I play the drum. David agreed and then said “The frog is not worthy.” This was a strange response and I wondered if David had been communicating his own feelings of worthlessness. After continuing to play together for a moment, David suddenly stopped and asked to play on his own. I listened to him play for a further three minutes. As he played the piano, he occasionally spoke. It was hard to hear the content of his language, but I got the impression he was repeating phrases from television programmes, something that he was reported to do when playing.

During this interaction, I was aware of David’s need to be in control. When I challenged this, he asked me to stop playing. As he continued to play on his own, he seemed to become rather self absorbed and I had to ask him to make an ending. Following this, David was keen to continue to play the piano and agreed that I could play the drum. He began to direct our improvisation, instructing me to play only when he played a particular note on the piano. It was interesting and significant that he began to tease me by getting ready to play the note, checking that he had my attention and
then at the last minute, deciding not to play in order to catch me out. He found this amusing and did it several times.

At the end of the session, I was left with rather a confusing picture of this boy. On one hand, he could interact playfully, demonstrating considerable social skill in his appropriate teasing of me. On the other hand, he was controlling, rather rigid in his approach and I felt his manner lacked warmth and empathy.

I decided to see him for a further assessment session in order to clarify my thoughts. This session took place two weeks later, on the day that David’s parents also attended the unit. David was excitable and began playing the piano immediately. Again, he asked me to listen to him which I did. After several minutes, I asked him to make an ending and introduced a game using eye contact and imitation. I wanted to assess David’s use of eye contact and humour. The game involved directing each other to play a particular instrument using eye contact and mime. David had no difficulty understanding the game, but seemed reluctant to play. He managed to direct me non-verbally but his directions became increasingly more controlling. He continually wanted to change the rules to play another instrument and I felt he simply desired to play on his own in a self-gratifying way.

David’s response was similar when I initiated another interaction where we took turns to play the slit drum. I had been clear in my instructions that we
were to take turns and David played first. After one minute, I stopped him and asked when I could have my turn. He said I could play now. I played a short rhythmic pattern and then David began to play. Again, he played for a long time and I stopped him to reiterate the idea of taking turns. David then looked at his watch and suggested that we each play for a minute and a half. I suggested that we each play for a short time and demonstrated. We started again but David was still unable to play for appropriate lengths of time. This interaction suggested his feelings of omnipotence and highlighted his inability to turn take appropriately.

Following the two assessment sessions, I was able to form a clearer picture of David’s difficulties. He had rather a complex presentation, particularly in the inconsistencies of his social skills. This had been seen in the group sessions during the assessment when he could be quite socially skilled with his peers, telling jokes and teasing. However, at times he could be rather rigid and controlling in his approach to social situations.

The team’s overall impression was of a boy who had feelings of omnipotence, who had difficulty relating appropriately in social situations. We all experienced him as lacking in warmth and empathy and his play was rigid and lacked imagination. His deficits in play were somewhat masked at times. For example, in the music therapy session, he had played spontaneously, responding to musical elements such as phrase and dynamics. However, he quickly became controlling and engineered situations where he could play on his own in a self-absorbed manner. In
the assessment of play with the occupational therapist, David had played with the train track. After laying the track he pushed the trains round but was unable to engage in any imaginative play. Even when the occupational therapist suggested the trains might be going somewhere he demonstrated his concrete thinking by saying they were going “over there”.

During the team discussion, it was felt that Asperger’s syndrome was a likely diagnosis for David. Although at times he could be quite socially skilled, he lacked empathy and his use of language was rather strange and pedantic. David often uses adult phrases as well as dialogues from television programmes that he watches. His imagination was clearly limited and he struggled to relate to his peer group appropriately. In addition to these difficulties, David has motor skills deficits and the team needed to take these into account when making a diagnosis. At the time of discussion and at the time of writing this case study, we are still waiting for further background information from the referrer. This would include a full developmental history and information from school. Without this information, we are unable to make a complete assessment and have had to postpone our conclusions. David’s presentation was unusual and complex and though Asperger’s syndrome seems likely, details regarding his early development need to be confirmed.
Case Three - Alex

Alex was referred for a general assessment of his behaviour. Aged ten years old, Alex lives with his father, step-mother and two half-brothers, having been rejected by his natural mother when he was a baby. He has a sister who lives with his mother. Alex’s mother had recently returned to the area with promises that she wanted to become more involved in his life. However, none of this had happened and Alex clearly experienced enormous feelings of rejection. Alex presented with both physical and verbally aggressive behaviour. He had been out of school for nearly twelve months as his teachers were unable to cope with his behaviour. His father had his own mental health problems and frequently admitted himself to hospital, leaving Alex’s step-mother to manage him. Alex was reported to be jealous of his half-brothers and his relationship with his step-mother was strained and difficult. As well as an assessment of his behaviour, there was a query regarding a possible diagnosis of ADHD.

In the psychiatric assessment, Alex presented himself as having no angry or worried feelings. He was unable to think about this as a possibility and the main purpose of the music therapy assessment was to see if Alex could access his emotional world non-verbally.

During the assessment session, Alex engaged readily. He began by sharing the bodhran with me and played loudly. He expressed surprise when I also played loudly. He avoided eye contact during this first interaction and seemed a little anxious. During some free improvisation
with Alex playing the drum and me using the piano, he played expressively, listening well and responding musically.

We had an interesting interaction sharing the slit drum sitting on the floor. To begin with we took turns to play and I noticed that Alex played very creatively, exploring the whole of the drum. He had no difficulty taking turns and was engaged in the musical dialogue. After some time, I suggested we play at the same time. Alex joined me in playing, but avoided playing on the same drum surface as me. I felt as though he was avoiding close contact and that the musical dialogue had been significant for him in terms of being listened and responded to.

Alex left the room when we finished playing the slit drum to use the toilet. On his return he mentioned his glasses that were in his bag. He told me that one of the boys in the group had made “nasty comments” about the glasses. He became withdrawn and sad and I commented that he seemed upset, but he was reluctant to think any further about his feelings. After this verbal exchange, Alex chose to play several different instruments in a free improvisation and asked me to play the piano. I felt that this improvisation was providing a container for Alex’s feelings as well as helping him create some distance between the current situation and what he had just said.

I wanted to see if Alex could relate music and emotion in another way and introduced a game of making expressive faces for each other to play. He
played expressively and also made a variety of faces including angry, sad and shocked. He seemed comfortable with the idea that an emotion could be represented musically.

When summarising the music therapy session, I found that Alex was able to use the non-verbal medium of music to express himself and interact. He seemed to enjoy the shared musical interactions, though I had a sense of him not quite letting himself go. His low-self esteem was evident and he seemed rather anxious at the start of the session. His anxiety returned towards the end when he became concerned about putting his glasses back on. I felt that Alex had been comfortable working non-verbally and that he had been able to access and express his emotional world.

The team felt that Alex had very low self-esteem and was struggling to manage a difficult family situation. His father was not in a position to support him and Alex’s feelings of anger and resentment towards the adults in his life was understandable. Although his behaviour was, at times, impulsive, there were no grounds for a diagnosis of ADHD.

Given that Alex had been excluded from school for so long, the team felt it might be helpful to consider a residential placement for him. This would mean that Alex could continue his education in a supportive setting, hopefully boosting his confidence and self-esteem. It was hoped that when he returned home for the weekends, his father and step-mother might find him more manageable. Some kind of non-verbal therapy might
be useful for him in the future when his environment was more stable and able to support therapeutic work.

4.2 Family assessment

i Introduction

As stated in Chapter One, the family assessment package arose from referrals that were made to assessment days. Families attend Tanglewood for two days and a programme is devised to meet each family's needs. The programme always includes structured sessions and unstructured sessions. As well as creative sessions, there are opportunities for the family to discuss their needs and difficulties as individuals and as a group.

This package has evolved from clinical practice and it draws on an eclectic mix of systemic, behaviouralist and psychodynamic models as well as assessment of parenting and behaviour management strategies to offer a multi-disciplinary assessment.

Experience has shown that families often regard the assessment at Tanglewood as a positive experience and sometimes the team can engage a family where the out-patient worker has been unsuccessful. The environment at Tanglewood is relaxed and informal with staff sharing meals with the family. There is an emphasis on having fun in many of the
sessions. This atmosphere would appear to be conducive to enabling families to relax and engage, allowing for insight into the family dynamics, constructs and realities.

The assessment seeks to understand the family, their strengths and difficulties. Generally one individual (a child) is identified as the location of the problem and the assessment looks at the functioning of the child and siblings within the family in order to gain understanding of the presenting difficulties.

ii Family Assessment Programme

As the approach to family assessment is flexible, adapting to and accommodating each family's needs, the structure of the assessment can vary. However, I will give a general idea of the programme offered. (See Appendix 2 for recent programmes.)

The mornings are taken up with group activities. The creative session is a structured one followed by a more informal time of play outside where a variety of playground and climbing equipment is available. The observed play session takes place indoors where a variety of equipment is provided including games, construction, dolls house and sometimes soft play equipment. This session is observed via video cameras. After lunch the parents and siblings have separate meetings with staff and this is also the time when individual assessments are carried out.
It seemed appropriate to offer music therapy as part of the family assessment as it has been so useful in children’s assessment days. If time allows, two sessions are offered. Though recently the music therapy assessment has taken the place of the second creative session. If this is the case, I co-work with an occupational therapist who plans the first session.

The first creative session involves some co-operative creative work such as making a family picture or banner and playing a game together. During this session we are able to get to know the family in a playful and hopefully, non-threatening environment. The same two workers facilitate the second creative session, the music therapy session. This allows for consistency of observation and assessment and enables the family to feel relaxed and at ease with staff they have begun to build a relationship with.

iii Music Therapy Session

The music therapy session has the following focus:

- To observe how the family relate to each other in a playful setting using a non-verbal medium.
- To observe how the family relate to, interact and engage with the therapist and co-worker in this setting.
• To assess how the family communicate and respond to each other, to include: eye contact, level of concentration, attention to task, level of ease with which the family engage musically.

• To observe the family dynamics to include: behaviour, limit setting and relationships.

The assessment provides the opportunity to explore the medium of music for interaction, communication and expression in a safe setting. The session is facilitated using semi-structured activities including directed interactions and an opportunity for the family to have free choice.

The model that I use for the session developed from the music therapy assessment session carried out in children’s assessment days described above.

The session usually lasts for one hour and is planned in advance by the co-worker and me. Some degree of flexibility is needed in order to adjust the session plan if it becomes unworkable or if a different focus is required. A typical session will include the following elements:

• Warm-up/greeting using a bodhran. This is often extended into an interaction that explores the family’s creativity and spontaneity such as playing the drum in a particular way or like an animal.

• Choosing instruments for each other.
• Activity where each family member gets the opportunity to lead the group's music.
• Putting instruments away. Again this is often done creatively.
• Family piece of music or free improvisation.
• Activity involving eye contact and control, miming and imitation.
• Sharing a single standing drum or passing an instrument round the group to say goodbye.

It is important to stress the flexibility of approach to the session. The overall aim is for the family to have fun and enjoy being together and interacting in different ways. It is interesting to see families who have very little playful contact, experience playfulness in a non-verbal setting. In addition, a family's resourcefulness and capacity to work co-operatively is sometimes surprising given that it has not been evident in any other part of the assessment.

Here is a brief case example to illustrate this:

The Wilson Family had attended for a two-day assessment. The eldest boy was identified as the problem and was scape-goated and treated punitively by the parents. The family had difficulty engaging with creative tasks. Outdoor play sessions were chaotic with parents demonstrating little control. When given the opportunity to make a family piece of music however, the mother instantly organised her family, sharing out roles and instruments fairly and evenly. The family all contributed to a lively
rendition of a current pop song demonstrating a sense of cohesion, playfulness and co-operation with parents clearly in control. Thus the family took the opportunity to show us how positively they could function all together and we were able to point this out as a strength that could be built upon.

The music therapy assessment session has developed from clinical experience and feedback from the multi-disciplinary team. Following each day of the assessment, the team meets to feed back information from the sessions and discuss observations about the family. This discussion helps to focus the following days sessions more closely on areas we feel need exploring and can enable me to structure the music therapy assessment session so that it addresses some of the identified areas.

An example of this is the Grant Family. Adam is the youngest of three children attending assessment with both parents. The referral had stated that Adam avoids eye contact and the team had noticed this on the first day of the assessment. By introducing an activity to the music therapy assessment that required family members to watch each other and respond to non-verbal cues, I could assess the way in which Adam used eye contact more fully. In fact, this showed that whilst Adam avoided eye contact at times of pressure, he was capable of spontaneous eye contact during a playful interaction. As well as paying attention to his sister who was leading an activity, it was observed that Adam turned to look at his
mum, as if to check her response to his sister’s playing. This showed that
he could also relate to family members appropriately.

The music therapy assessment session offers another framework within
which to assess the family. Everyone, including the therapists’ are active
and participative. This can help relax the family who may have found the
experience of being observed quite stressful. The use of the non-verbal
medium also offers something different and can enable more silent family
members to contribute. Using various structured activities as well as some
free choice, can enable the therapist to set up situations in order to
explore how the family communicate for example. Communication and
relational difficulties can be observed in a concrete way as they are played
out in the music. For example, the child who cannot stop playing the drum
or the mother who is unable to lead the family.

The session is unique in the way in which it explores communication and
family dynamics. Valuable insights can be found and a useful contribution
is made to the multi-disciplinary assessment process, complementing the
other areas of assessment such as psychiatric evaluation, family meetings
and non-directive play sessions.
The Grant Family

I have already mentioned the Grants who were referred for a family assessment to gain a greater understanding of their difficulties and to observe them functioning as a family unit. The family consisted of Adam who was described as having difficulty relating socially with poor motor skills and some attentional problems, Caroline who had not been attending school and Kelly who had been bullied at school and also admitted to bullying smaller children. Mrs Grant had mental health problems stemming from a long history of abuse by her parents, who were both health professionals, and further abuse when she was taken into care.

As stated earlier, (Chapter Two, p33) it had been important to engage this family in the work at Tanglewood and much attention had been paid to creating a positive working alliance. The music therapy assessment gave the opportunity to assess the family’s communication and relationships non-verbally.

I would now like to describe some aspects of the music therapy assessment more fully. The family were initially reluctant to take part in making music. It is interesting that it was an activity involving leading that engaged them, as control seemed to be an issue for them. Each family member took it in turns to lead the music from a large drum. Adam took great pleasure in the sense of control he had over his sisters and parents,
smiling broadly as he played loud rhythmic beats. As the youngest in a
boisterous family, it must have been quite a novel position for Adam to
have everybody paying attention and listening to him. This interaction also
showed that he had the capacity to lead independently and confidently,
relating appropriately to each family member. This was something that his
parents had questioned.

When Mrs Grant led the music, neither Adam nor Caroline appeared to be
listening at first. However, Mrs Grant was able to engage them through
playful interaction and eye contact. There was also a particularly warm
interaction with her and Kelly who often seems to be excluded from Mrs
Grant’s close relationship with Caroline. This showed Mrs Grant
successfully relating to all three of her children, using effective non-verbal
skills to engage them in her actions. It was useful to see this as there
were times when the team felt she did not engage appropriately, for
example, striking up a very sisterly relationship with her older daughter
and then being unable to set a limit for her.

Mr Grant led the music confidently and we noticed that the whole family
were particularly attentive to him, listening and following carefully. It was
interesting to see the family relate to Mr Grant in this way as he was
regularly undermined by his wife and often refrained from managing the
children’s behaviour. He appeared to enjoy the experience of being in
control.
The issue of control was explored further in another activity that used eye contact and mime. One family member directed another, miming how they should play a particular instrument. The family enjoyed this activity and were creative with their miming. Mrs Grant took the opportunity to make her husband look silly by miming energetically how he should play the ocean drum. Mr Grant engaged well with this, showing the parents as united. He then chose to mime how I should play the ocean drum, making me look very silly. The result was that the whole family began to laugh uncontrollably. Mr Grant was clearly proud of the effect he had on his family, stating ‘I’ve got the four of them falling about!’ This seemed to be a significant experience for the family as they engaged with and responded positively to the professional team, rather than presenting a united but hostile front as they had done when seen in the out-patient setting.

The music therapy assessment helped to confirm some things we already knew about the family. They are playful, warm and caring and have no difficulty interacting with one another. In addition, the session gave us insight into the family dynamics: the sibling rivalry between Caroline and Kelly and the way in which Mrs Grant sometimes struggled to manage this. We saw the strong bond that exists between Mrs Grant and Caroline in the way they chose instruments for each other and no one else in the family. We observed Mr Grant taking a more dominant, playful and interactive role than had been seen elsewhere in the assessment. This suggested that he was perhaps more comfortable with non-verbal interactions, but most
importantly showed that he could be effective in engaging and managing the children when given the opportunity.

We were able to observe Adam more closely and found him to be somewhat distractible, with poor motor skills. We also noticed that either Mrs Grant or Caroline tended to talk for him or prompt him to do something, rather than encourage him to be independent and learn new skills. When given the opportunity to lead on the drum, Adam demonstrated his capacity to remain attentive and engaged and interacted appropriately with other family members. Mrs Grant expressed her surprise at his level of concentration and initiative during these interactions.

The music therapy assessment was also significant in the way in which the family were engaged and their attention maintained. This had a positive effect in addressing Mrs Grant’s resistance to professionals. By being playful, we were able to find a way of being together that valued the family and reinforced the fact that the parents had good management skills as well as highlighting some of the underlying dynamics that affected their relationships.

4.3 Summary

Music therapy diagnostic assessment makes a unique contribution to the assessment process at Tanglewood. It has been particularly useful when assessing children with communication and language difficulties as their
social skills and non-verbal communication skills can be assessed. It has also been useful for children who have difficulty expressing their emotions verbally. As seen in the case of Alex, music therapy enabled him to access his emotions, showing that he could acknowledge the difficult feelings he had resisted talking about during the psychiatric evaluation. Alex had been defensive and resistant to the idea that his sad and angry feelings could be explored in any depth, though in the music therapy session, I felt that Alex had shown the potential to use music to do this.

Children are often motivated to explore the instruments. Therefore a child who is reluctant to engage in another setting might be more relaxed and able to interact musically. Issues around control and leadership can be assessed in the session as musical improvisation explores whether the child directs or waits to be directed musically.

The family assessment provides a novel experience for the family to interact together. Issues around communication are highlighted clearly in the process of making music. Strengths and needs of individuals as well as the family system can be observed and assessed. The session can also help to engage the family with the professionals on the unit as we all take part.
Chapter 5
Music Therapy with Families

5.1 Introduction

This chapter will present some case studies of short-term music therapy with families. As well as the family assessment sessions that have already been described, I offer music therapy treatment to families. Amelia Oldfield has written about her approach to work with families (1993) and I have been encouraged by her as my supervisor to establish this type of work at Tanglewood. Other music therapists have written about work with mothers and children (Warwick, 1996; Hasler, 2000; Levinge, 2000; Palmer, 2000 and Oldfield and Bunce, 2001). Oldfield and Bunce (2001) provide a useful literature review on music therapy with parents and children and also look at literature describing other types of therapeutic intervention for this group.

Music therapy with families at Tanglewood sometimes develops from the relationship that is established when the family attend Family Days. Other referrals are received from the out-patient teams. Occasionally, family work develops as an intervention or extension of treatment already taking place with an individual child. For an example of this, please refer to the case study of Brian in Chapter Six.

The music therapy offered to families is generally no longer than eight sessions, with most families receiving four sessions. If the focus is to offer
the family a different, more positive experience of being together, then to continue for longer might result in losing this focus as more complex issues are encountered in the therapy process. If the family are motivated and engaged, then music therapy can have a significant effect in reframing negative patterns of interacting and relating as seen in these case studies.

As this intervention is brief, it is important to work closely with the referrer in order to hand over the case and enable the family to work through and process the experiences of music therapy following the end of sessions. This way of working at Tanglewood is particularly useful for those families where the problem is one of family dynamics and communication or attachment disorder. Working with the family or mother and child, helps to locate the difficulties in a more realistic way, rather than the child being seen as ‘the problem’.

5.2 Case One - Melissa and Jane

i Background and Reason for Referral

Melissa (age seven) had attended Family Days with her mother, Jane, her younger brother and sister and her step-father. The aim of this programme was to enable the parents to improve their behaviour management and to assess the family relationships in more depth. The family made considerable progress during their attendance at Family Days
and the parents demonstrated effective behaviour management
techniques with all three children. However, Jane’s relationship with
Melissa was still difficult. Melissa displayed challenging and attention
seeking behaviour. Separation from her mother was extremely
problematic and she appeared to have some difficulty in expressing her
emotions appropriately, alternately hitting out at her mother and then
cuddling her with great intensity.

In team discussion following Family Days, it was felt that Melissa had an
attachment disorder. Jane had described the traumatic events
surrounding Melissa’s birth at twenty-nine weeks gestation. Mother and
daughter were separated following an emergency caesarean section and
Melissa was in intensive care for three months, receiving oxygen for most
of that time. When Jane finally held her daughter, she described feeling
helpless and not knowing what to do. She recognised that there had been
a problem bonding with Melissa when she had her second child, who was
born without complication and with whom Jane has a good relationship.

As well as recognising the attachment disorder, it was important to look at
Melissa’s difficulties that were associated with being born pre-term and
ensure that Jane had a realistic perception of Melissa’s needs and
strengths. She had some motor skills deficits and some attentional
problems. As a result of these difficulties, Melissa was rather clumsy and
we felt that Jane often saw her clumsiness as intentional, for example, if
Melissa accidentally knocked into Jane, Jane would tell her off. The team
felt that music therapy might provide an opportunity to explore and recreate the early interactions between Jane and Melissa that had been missed out on. The sessions might also help to re-frame Jane’s perception of Melissa’s erratic physical behaviour in a more positive way.

ii Summary of Sessions

Four music therapy sessions were facilitated by myself and an Occupational therapist who would continue to work with the couple when the sessions had ended. Though keen to engage in music making, Melissa’s concentration was poor and she acted out in the sessions, hitting and kicking her mother. Jane was effective in gaining Melissa’s attention and used praise as a way of encouraging Melissa to engage. However, it was felt that Jane was rather flat in her approach to Melissa and her praise lacked warmth and genuine emotion.

In the second session, we focused on music making that involved physical activity, exploring Melissa’s reaction to proximity and distance to her mother. She enjoyed hiding and being found by her mother, greeting her discovery with squeals of delight and physical affection. A free improvisation with mother and daughter sharing the bass xylophone, ended in Jane stroking Melissa’s hair and tickling her feet. She stated that when Melissa was in intensive care, she was only able to touch her feet. This seemed to be a significant way of interacting for them as Jane showed genuine warmth and maternal affection.
The third and fourth sessions continued to look at the early interactions. We noticed that at times Melissa wanted to be a baby with her mother, sucking her thumb and cuddling up or choosing to do things in a babyish manner. Jane found this difficult and would remind Melissa that she was a “big girl” and not a baby. We felt that the sessions could provide a place where Melissa could be a baby and asked her to bring in some of her baby things. She arrived with the blanket that she had first been wrapped in and told us that she still slept with this. She also brought a tiny cardigan that she had worn. Melissa cuddled up to her mum as we sang a gentle hello song that developed into a song about being different animals.

The final session was very difficult for Melissa. She arrived looking sullen and was reluctant to engage. Jane encouraged her and eventually, Melissa initiated a musical game of hide and seek, asking us to close our eyes and then find her, an instrument or a doll that she had brought. Melissa took part in an interaction using a large drum to say goodbye, though was clearly distracted. She then took her shoes off and refused to leave the room. Jane had to carry her out.

We felt that Melissa was very angry at the end of the sessions as she had enjoyed having time with her mum on her own. Their musical interactions had led to Jane expressing her love and warmth towards Melissa in a more genuine way. Melissa had in turn allowed herself to explore being apart and with her mother in the hide and seek games. Music therapy had allowed mother and daughter to experience being together in a novel
situation where they could learn to relate to each other again. Melissa’s angry feelings as the sessions ended were therefore understandable.

### Review

Following the end of the sessions, we had a meeting with Jane to review and discuss the process of the music therapy. This took place two weeks after the final session and Melissa had had a birthday. Jane began by saying that she had not enjoyed the sessions at all and found that her relationship with Melissa still felt strained and uncomfortable. We were keen to give her some positive feedback regarding the quality of her interactions with Melissa, her ability to contain, engage and distract her daughter.

As we talked, Jane began to describe her feelings around Melissa’s recent birthday. She said that for the first time she had allowed herself to think about Melissa’s birth, becoming extremely upset as she remembered this traumatic time. As the session came to an end, Jane reviewed her feelings and said that she did feel differently towards Melissa. She felt she could understand why their relationship was so complicated. She recognised Melissa’s difficulty in letting go of her, but also felt that things were beginning to improve. She felt that spending time with Melissa in the music therapy sessions had enabled her to become closer to her daughter and also put their relationship in context by realising what they had missed out on when Melissa was first born. A series of follow-up play sessions
were arranged with the occupational therapist. These sessions aimed to continue to enable mother and daughter to relate positively in a therapeutic and supportive environment.

iv Reflections

Music therapy seems to have been effective in addressing some of the attachment issues in Jane and Melissa’s relationship. The family were already engaged in therapeutic work at Tanglewood and their level of engagement and commitment remained high. They lived some distance away and as Jane did not drive, they had to make a long journey on public transport. Jane was determined to work towards a better relationship with her daughter and this commitment must have had a positive effect on the therapy sessions.

The use of music was a novel experience for Jane and Melissa and focused the content of the sessions clearly on interaction. This interaction and the experience of being and playing together acted as a catalyst for change in the mother/daughter relationship. In the first instance, music was more appropriate than play as a medium as Jane was interactive. When Melissa played, she tended to sit back and watch rather than become involved and interactive. The use of music therapy helped prepare Jane and Melissa to use the play sessions with the occupational therapist more productively.
5.3 Case Study Two - Amanda and Jake

i Background and Reason for Referral

Amanda and Jake had attended Family Days with Jake's younger brother, Harry. Amanda and Jake had rather a volatile relationship with Jake directing aggressive and challenging behaviour towards his mother. Jake's behaviour was good at school and it was clear that the problems centred around his relationship with Amanda who had rather a negative view of him. In light of this, I suggested that I work with both of them. Music therapy was chosen as an appropriate medium as Jake had some communication difficulties, suggesting that a non-verbal and interactive form of working might be effective. A brief intervention of just two sessions was planned and following this, Amanda would continue to be supported by the psychiatrist who made the referral.

ii Summary of Sessions

Amanda and Jake attended two music therapy sessions. Harry was present for the second session. I saw Jake on his own for twenty minutes while Amanda saw the psychiatrist who was case manager. This was to enable Jake to explore music as a means for communication and interaction and assess how he responded to me in this situation. His mother then joined us for half an hour.
Jake was excitable in both sessions, keen to involve his mum in music making and demonstrating how well he could play. Amanda seemed unable to meet Jake’s enthusiasm and at first took part reluctantly. She also seemed to see Jake’s enthusiasm as negative, telling him he was playing too loudly or to “just calm down.” I suggested a game of taking turns to lead the music from a large drum. Amanda went first and began to enjoy the control she had over Jake, making him stop and start playing. When it was Jake’s turn, she found it difficult at first to let him play loudly. However, I commented that Jake really seemed to enjoy playing the drum and this comment encouraged Amanda to see Jake’s loud playing more positively.

In the second session, Amanda really seemed to have made progress in her perception of Jake. When they shared the bass xylophone, Amanda tolerated Jake’s loud playing and began to initiate some playful turn-taking interactions with him. This game extended into a lively improvisation with both Amanda and Jake smiling as they played. It was significant that Amanda allowed herself to interact so freely and playfully with Jake, particularly with Harry present in the session.

iii Review

Following the two sessions, I reviewed the case with the psychiatrist. I described the positive changes that had taken place in the sessions. Amanda had been enabled to adjust her responses to Jake, focusing on

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his positive behaviour rather than seeing all behaviour as negative or disruptive. As she allowed herself to become more playful, Jake became less provocative and more appropriate in his interactions. These sessions had a dramatic effect on the way in which mother and son related to one another. The psychiatrist continued to support the family and it was acknowledged that using a non-verbal medium had been particularly effective in addressing the difficulties in this relationship.

iv Reflections

It is clear that in just two sessions, positive change could be effected by addressing the relational and communication issues in this relationship. Whilst ongoing music therapy might have continued to address these issues, it was important to capitalise on Amanda’s motivation to change following Family Days. In addition, this family had a history of non-attendance and therefore, a brief period of intervention was more appealing.

The non-verbal approach enabled Amanda to see her negative responses to Jake more clearly. The focus of the sessions was about having fun together and in taking part, Amanda and Jake were able to re-discover their enjoyment in playing together. This was something that had become lost in the cycle of negative interaction.
Chapter Six
Case Studies: Individual Work

6.1 Introduction

This chapter will present two individual case studies. The purpose of these case studies is to illustrate the aims and objectives of short-term music therapy at Tanglewood. As stated earlier (Chapter Three), the short-term contracts at Tanglewood had a direct influence on the nature of work undertaken. These cases demonstrate the development of my approach to short-term music therapy as intrinsically linked to the clinical casework.

6.2 Case One. James

Background and reason for referral

James was first referred to Tanglewood aged seven years old. At the time of referral, he had behavioural problems and both school and his mother had difficulty managing his behaviour. His parents were separated and he lived with his mother. James stated frequently that he missed his dad with whom he had some contact, but not regularly. He attended Assessment Days at Tanglewood and a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) was confirmed accompanied with behavioural problems. Following this diagnosis, a Community Psychiatric Nurse (CPN) worked
with James and his mother but made little impact on their negative relationship. James was described by his mother as a distractible and unco-operative boy. His mother was exhausted and unable to manage his destructive behaviour. Tanglewood’s assessment report also commented on James’ low self-esteem and self-confidence and his high levels of anxiety. He was prescribed methylphenidate but had a poor tolerance to the medication, experiencing side effects including loss of appetite, weight loss and sleep problems.

Reports from school were poor and stated that James’ behaviour was disruptive and at times aggressive and that he was failing academically. After twelve months or so, the CPN who had been working with the family left the service. This coincided with the sudden death of James’ mother from a cerebral haemorrhage whilst on her honeymoon. James went to live with his father, Mr Philips and the case was taken over by a consultant psychiatrist. James had a good relationship with his father who preferred to manage his behaviour using behaviour management strategies and requested that methylphenidate was stopped. James attended the ADHD treatment group at Tanglewood (see Chapter One) and had some individual sessions with the consultant.

James made progress in the ADHD group. When engaged, he was reported to be attentive and seemed to be a bright boy with a lively sense of humour. However, he was impatient and distractible and had difficulty sticking to limits. As the ten week group progressed, James’ behaviour
improved. His relationship with his dad was positive and he seemed more contained. However, he was still experiencing difficulties at school and had in fact been excluded several times. Following the end of the ADHD group it was suggested that James would benefit from attending a second ADHD group in order to consolidate the skills he had learnt. It was also felt that he might benefit from some individual therapy to help him look at his feelings. The referral to music therapy describes him as follows: ‘He is not a verbal boy and his father wonders how well he manages his feelings of sadness and anger. James likes music, especially the drums and guitar. We wondered if music therapy might help him to express his understandably intense and negative feelings.’

James was offered an initial assessment of four music therapy sessions. He began attending the second ADHD group just after these sessions started. I will continue by describing the sessions in detail and the case study will end with an examination of James’ progress both in sessions and at home.

ii Summary of sessions

Sessions lasted approximately forty-five minutes and were weekly. James was quick to engage and seemed relaxed in the environment. He interacted positively and playfully and seemed to enjoy exploring the instruments in a creative manner. Even in this first session, James’ improvisation was sensitive and expressive. We shared long
improvisations that involved elements of phrase, structure and rhythm, call and response and an easy sense of rapport. He was confident and played loudly, pushing the instruments to their limits. There was a moment when I felt concerned that he might break the drum or the beater as he was playing so forcefully. James also showed a capacity for quieter, more reflective improvisation using instruments such as the slit drum and the guitar. He initiated a blues style rap demonstrating his sense of ease in the music therapy environment as he danced and sang/rapped whilst accompanying himself on the drum.

James left this first session with a sense of looking forward to the following week. I felt it was significant that he greeted his dad with a warm hug. James brought a guitar with him for the second session. His dad asked if I could tune it. In the music therapy room, James said his guitar was no good and asked if he could swap it with mine. As with the first session, he engaged immediately with free improvisation. He played in a focused manner and the improvisations were reciprocal. We seemed to develop some musical connection within which to listen and respond to one another. After a long, loud and intense improvisation during which James had played the drum, there was a pause. I commented on the volume and James said he liked it because he could feel the vibrations in his arms and head. I expressed concern that I thought something might break. James said he thought that his hands might break.
Towards the end of this session, I began to tune James’ guitar. During the process, one of the strings broke. James thought this was very funny and it was at this point that his concentration and attention seemed to decrease. He became less engaged and acted quite impulsively, jumping up and down and talking and laughing constantly. At the end of the session, after reflecting on the event, I felt it necessary to suggest that James should calm down before leaving the room. He was able to sit quietly and then, on the way down the stairs, he expressed concern about the broken string. He said he would tell his dad that he had broken it so that I would not get into trouble.

James attended the third session and began playing the drum. This was an energetic improvisation with me supporting him on the piano. During this intense and expressive piece of music, James played so vigorously that a beater he was using broke in two. As this happened, I was aware of the connections between the broken guitar string, the beater and the ‘broken’ relationships in his life. I chose not to verbalise these connections at the time, as our relationship was at its beginning. I also felt that James was able to process some of the connections himself through his music making and wanted to continue to explore our relationship as built in musical improvisation. He seemed quite shocked at having broken the beater and immediately said that he could mend it. He then said that he was trying not to laugh because it was not really funny.
In contrast to his response when I broke the string on the guitar, James remained contained and suggested that we play some different instruments. A slow and thoughtful improvisation followed. He used the guitar, slit drum and rainstick whilst I played the piano. When the piece, which lasted nearly ten minutes, ended, James said he had enjoyed it. I commented on the space created by the music as space to think and reflect. He clearly felt contained in this session. He was reluctant to leave and attempted to prolong the ending by asking me personal questions. This demonstrated his awareness of and capacity to challenge boundaries and the time limitation on our sessions.

Our fourth and final assessment session began with a discussion about how James felt about attending music therapy. He spoke articulately and said that making music made him “feel happy”. He said that he would like to continue attending. This session coincided with him being excluded permanently from school.

During the session, our music making was involved and intense with a long improvisation to start with. James used a variety of instruments, swapping between the djembe (African drum), standing drum, piano and guitar. When he played the guitar (open strings), I supported him on the piano. He stopped to ask me to play some “happier music”. James played with a strong sense of purpose. His use of rhythm and melody was complex and had a sense of urgency in its communication. My musical
contribution in this session seemed to be particularly important as the music was very conversational.

I asked James to choose some instruments to represent members of his family. Among them, he chose the djembe for himself and the chime bars for his mum. We improvised with these two instruments, I played the djembe and he used the chime bars. The music created was quick in tempo and at times James played with a great deal of force, knocking the chime bars over as he played and then gently and carefully placing them upright. At the end of the session, it was interesting that he put the instruments away with enormous care, thinking about the position of each one. He said that they would all be in the same place when we met next week. I reminded him that the meeting next week was to talk with his dad and the consultant and that we would not be making music. He expressed his disappointment verbally and was reluctant to leave but did so good naturedly.

iii Review

The review meeting, which was arranged by the referring consultant and myself, was attended by James, Mr Philips and his partner, Ms Smith. Prior to the meeting, the consultant and I had discussed the options available regarding further music therapy. I felt that I would like to offer James at least four months music therapy sessions with the possibility of this being extended. However, my contract was temporary and we could
only plan for the next two and a half months at that time. We encountered a dilemma in that if music therapy sessions continued for that period of time, then the ending would coincide with the ending of the ADHD group. It was felt that this would not be helpful for James, given the sudden and unexpected loss of his mother and the difficulties with school. We did not want to repeat the experience of multiple and sudden loss and felt it was important for James to experience a planned ending. After taking everything into consideration, we decided to offer another four sessions. This would take him through the anniversary of his mother’s death twelve months ago and would give him a chance to prepare for and work through an ending with me.

At the review meeting, James’ progress in the music therapy sessions was discussed and James stated clearly that he would like to continue attending. We agreed to have another four sessions. The situation regarding his exclusion from school was discussed and then suddenly Mr Philips’s partner, Ms Smith asked James and his father to leave the room. She began to talk about things going missing in the home and said that she was sure James was taking items but he denied it when confronted. The consultant suggested talking this through with James and his father in the room. James handled the discussion maturely and although reluctant to talk about taking things, he listened as his father and Ms Smith talked to him. Surprisingly, James began to talk openly about his grief at losing his mum. He described his feelings about her death and talked about feeling angry with her and with his dad.
This session seemed to be a moment of change for James where he acknowledged some of his difficult feelings in a mature way. It is also interesting to note that he linked his feelings of anger to the music therapy sessions and said he thought it was probably better to bang a drum than bang a door or something much worse. It also showed that James was aware of the support he had within his family as he described an intense but loving and caring relationship with his father.

iv Ending

The focus of our final sessions together was to enable James to continue to use music expressively and creatively, to think about some of the emotions contained in his improvisations and explore these musically or verbally as appropriate. The session would also offer James a constructive outlet for his physical energies.

James attended three out of the four sessions. One session was cancelled by the therapist.

James continued to attend sessions readily and engaged quickly in music making. Session five began with him using the ocean drum, playing very gently and then, with a loud crash, he said the man had been drowned and was dead now. An improvisation on the piano followed immediately and James played two distinct motifs. In the treble, he played a quaver pattern on two notes. In the bass, he played the bottom five notes in a
descending pattern, loud and slowly. This was unaccompanied except for some gentle support that I offered on the djembe. The improvisation was intense and seemed to be filled with emotional content. James left the room immediately afterwards to go to the toilet. This might have been a way of relieving his intense emotional state. When the session ended, he was reluctant to leave. On the way out of the room, he said he did not like saying goodbye and I wondered to myself, if he was thinking of his mother. It was the anniversary of her death in a few days time.

The music therapy sessions were clearly valuable in enabling James to access and express his feelings in a way that he could not do verbally. He seemed to be using the sessions to explore his feelings relating to his mother’s death and I wondered if we had enough time to look at this. I felt concerned that I would not be able to contain his expressions in the short time available and that James would not be able to process and work through his feelings.

I had to cancel the following session due to illness. In supervision, I discussed my feelings of guilt at having to cancel and my concerns over the lack of time we had. I also talked about how to approach James’ feelings regarding his mother’s death which I felt to be present in the sessions. I wondered if I should talk about his mother or not and after some discussion, felt that James might bring it up himself. I also wondered whether our music making was sufficient to contain his
expressions and if he needed any verbal intervention to process some of his experiences in music therapy.

James attended the next session and said “Hello Claire, I hope I enjoy today’s session.” This comment suggested James’ concern about making the most of the time we had together. I also felt a certain pressure to facilitate the right sort of space for James, so that the next two sessions could form a satisfactory ending. He began by improvising on a variety of instruments, arranging several round him as he sat on the floor. He played for nearly twenty minutes like this and I provided a secure bass line on the piano. This seemed to enable him to explore his feelings and he played enthusiastically. The piece had a celebratory, uplifting and joyful feel to it and when it ended, James sat down in a chair with a sigh and said: “it made me feel full of joy!” I felt as though James was celebrating the opportunity to express himself.

He went on to use the electric piano. As in the previous session, he used two contrasting motifs. This time, he used the organ sound and the electric piano sound. With the organ sound on, he put all the keys down and played loud chord crashes. The sound was very loud and I said I thought it sounded as though someone was screaming. He used the electric piano sound to create cheerful, dance-like music. James commented on the contrast between the sounds and said he liked the happy music best. He continued by saying that sometimes when he “felt low”, he liked sad music. I asked what made him feel low. He replied: “I
miss my mum." I suggested that we could make a piece of music for her and he said he would like to do that. James asked me to play the guitar while he played the glockenspiel, tambourine and guiro. The music was bright and had a light tempo. When he finished playing James said he was pleased with it and thought his mum would have liked it.

In this session, James was emotionally involved and expressive right from the start. The session was significant in that he was able to link his musical improvisations with his feelings about his mum. I felt that the contrasting piece on the piano had given his feelings some form that he was then able to reflect upon. I was also impressed by his maturity and openness and his ability to allow himself to think about his sad and angry feelings.

James arrived for the final session with Ms Smith. This was unusual and Ms Smith informed me that she had told James off, that he was probably in a bad mood and would beat the drums very loudly. James did not say anything and ran upstairs ahead of me into the music therapy room. He began playing immediately, still without speaking. He played on a large standing drum, loud and with some aggression. I mirrored his playing on the piano with dissonant chords and the music felt both angry and sad. There was a great crescendo and James stopped playing the drum at a point of climax. He looked at me and picked up a small glockenspiel. He played a descending scale of C major. This was slow and purposeful and I was held by James’ control after his improvisation on the drum. I
repeated the scale on the piano and a new improvisation began. While I maintained the simple chord sequence that the scale had suggested, James gradually introduced other instruments, playing in a communicative and expressive manner. The music was syncopated and moved to a lighter though still engaged mood.

The improvisation ended and James then requested the same chord progression. He continued to play a variety of other small percussion instruments. As we played again, the music continued to be fluid and expressive and I was reminded of the piece that James had played for his mum. I also felt that he experienced this improvisation as safe and containing. His posture was relaxed and his eye contact was warm. When we stopped playing, I reminded James that this was our final session. We had played for thirty-five minutes and I commented on how expressive I felt his music had been. We talked briefly about how he felt when he improvised and he acknowledged that the sessions had been important in allowing him to think about his feelings. He went on to say that the music he had played on the glockenspiel had been for his mum.

When it was time to end, James chose to use “an old instrument” to say goodbye. He picked up the bodhran which had been the first instrument that we played together. He said: “give it your best shot!” and we took turns to hit the drum very hard.
This final session shows how significant improvisation was for James. It is interesting that there was no need for words when the session began. James led the improvisation and communicated clearly his feelings and thoughts. He seemed to find a containment within the music that enabled him to progress from his initial anger to a more relaxed and reflective position.

Following a break for the Christmas holidays, the consultant and I met with James, Mr Philips and Ms Smith. James approached this review meeting with maturity and was keen to share his feelings about his music therapy sessions. He talked openly about how important the sessions had been and said that they had been helpful because it was better to express himself by playing something than slamming a door for example. He also described the music that he had made for his mum. It was also appropriate at the meeting, given his diagnosis of ADHD, to mention his impeccable behaviour throughout the sessions and the way in which he had managed to prepare and experience a planned and constructive ending. Mr Philips commented on a positive change in James, saying that he was calmer and more communicative about his feelings.

Reflections

The case study described above includes some of the most profound and intense sessions I have experienced as a music therapist. Both myself and the consultant in charge of the case were surprised at James’
progress in this short time. He attended seven music therapy sessions and two review meetings over a period of twelve weeks. Before considering why this piece of work was so effective for James, I would like to briefly outline his progress following the end of sessions.

He continued to attend the ADHD group and his behaviour showed marked improvement from the sixth session of the group. This coincided with the end of music therapy sessions. By the eighth week of the ten week course, James showed no evidence of hyperactivity or impulsivity and was observed to be attentive and sensitive to his peers. In the group, James himself commented on the change in his behaviour. He said that it had not been easy to change but that it had been necessary and now he had friends. He was able to express his emotions constructively in the group and commented insightfully about a peer who was having difficulty doing this. In the final session of the group, James performed a rap about the experience. The last line of his rap was: “I’d like to come back but I haven’t got attention deficit!”

When the ADHD group finished, James was still out of school. However, he attended a follow up appointment at the beginning of the summer term in a new school uniform looking bright and confident. The consultant informed me that his original diagnosis of ADHD was being questioned. He had clearly made enormous progress and was settling well into a new school. The case was closed some three months later.
It would appear that this brief period of music therapy offered James the outlet he needed to explore his intense and difficult feelings regarding his mother’s death. The sessions were characterised by an early rapport and a positive therapeutic alliance. This was seen in James’ ease in relating and using music to express and communicate. He also seemed to benefit from the therapeutic relationship, particularly the opportunity to express himself, to be heard and responded to. The non-verbal medium seemed to allow James to access his feelings quickly and afforded him a vivid and interactive means of expressing them.

As mentioned, I felt concerned that we would not have enough time to work through the material James was bringing to the sessions. I discussed these worries in supervision, particularly my concerns about whether to verbalise the connection I felt James’ improvisation had with his feelings about his mother. Following this discussion, my focus was on trying to hold and contain James’ musical expressions rather than begin a conversation that we may not have time to explore fully. As I responded musically to offer a safe, containing space, James was able to verbalise some of his feelings in an insightful way. It had been important for me to hold back and to allow James to process his feelings through his improvisation.

Music therapy was clearly an appropriate and successful way of working with James. The important elements would appear to be the early development of a rapport and positive therapeutic alliance, a trust in the
process of the therapy and acceptance of the time limit. The first four sessions seemed to act as a catalyst for change, seen in James’ verbal contributions to the first review meeting where he talked about his feelings towards his mum and dad.

The sessions that followed this were characterised by intense and involved improvisation through which James expressed and began to work through some of his feelings. It felt as though the time limit enabled James to address feelings that he might otherwise have continued to repress or express inappropriately.

There were several other factors that were present in helping James to make the changes that he did. These were the support and commitment offered by his father and Ms Smith, James’ membership of the ADHD group and the involvement of the consultant psychiatrist.

6.3 Case Two – Brian

i Background and Reason for Referral

Brian was referred for a music therapy assessment by a consultant psychiatrist in child and adolescent mental health. He is the middle of three sons and was aged nine years old at the time of referral. Brian suffered from hypothyroidism and had stuttered for several years. His stuttering appeared to be linked to anxiety and the parents’ main concern
was his temper outbursts at home and the way in which he isolated himself from the family. The referrer felt that music therapy might be helpful in enabling him to express himself freely and address some of the issues connected with his temper outbursts. Despite his parents’ concerns that he would not achieve at school, reports from his teacher were good and he seemed to have no difficulty making friends.

There was a family history of hearing and speech problems. Brian’s father, Mr Thomas was deaf and relied on his wife to interpret and speak for him. English was not the family’s first language and Mrs Thomas herself spoke little English. She often relied on her son to interpret for her.

After meeting Brian and his parents, I decided to offer Brian two assessment sessions. This would give me some impression of how he interacted using music and whether it would be useful to continue with sessions to explore his interactions and communications further.

Brian engaged well during the assessment sessions and was able to use music as an effective means of non-verbal communication. He demonstrated a capacity to play creatively and expressively and also showed some understanding that he could express his emotions in this way. In addition, I felt that Brian enjoyed the interactive element of improvisation and that the free and relaxed flow of musical improvisation was a positive experience for him. As a result of the assessment, Brian
was offered a further six sessions following the Christmas break. These sessions were weekly.

ii Summary of sessions

During these sessions, Brian continued to be engaged in music making. The sessions often began with him keen to play something. His musical improvisation was characterised by energetic and fast playing and our improvisations were short, ended by Brian. He would then look to me as if waiting for me to give the next instruction. This pattern of a succession of fast and short improvisations emerged in the first two sessions. I felt it was important to keep in mind the reasons for his referral to music therapy and was reminded of his tempers and apparent need to control situations. This was clearly evident in our improvisations together and Brian also commented several times in response to my observations, that lots of things in his life were “fast and loud.”

By the third session, I had decided to challenge Brian’s need to control in a positive manner. After commenting on his skills on the hand drums and his fast rhythmic playing, I suggested that we might play something slow. Brian found this very difficult and played quick rhythmic patterns on the drum followed by a pause. We continued to practise playing slowly together and I also challenged his need to end each of our improvisations by introducing a turn taking structure. This meant that when it was my turn and Brian wanted to end, I could insist, playfully, that we continue playing.
It was important to challenge Brian’s style of playing and see if he could play in a more variable manner. I felt that his fast playing represented his approach to life, where little time was allowed for reflection and consideration, hence his frequent temper tantrums. I wanted to see if he could slow down and be less controlling.

I felt confident that the approach I had taken with Brian was appropriate as his parents were supportive of the music therapy sessions and were keen to address the difficulties they experienced with his behaviour. I was challenging Brian’s need for control and therefore, this support and commitment from his parents was vital. He responded positively to my musical challenges and was able to explore other ways of playing. He clearly enjoyed improvising and his self esteem appeared to improve as he responded to praise. He demonstrated a capacity to listen and play more reflectively which I saw as a positive development.

iii Review

Following these individual sessions, I had a review meeting with Brian and his parents. Brian recognised a change in his behaviour at school and said that he found it easier to control his temper. He also commented that he did not seem to rush around so much. When I asked how things were at home, he shrugged and said “Okay”. Mrs Thomas described the way in which Brian and his brothers squabbled and then acknowledged that their
fights seemed to be part of growing up together. She did feel however, that Brian still had difficulty controlling his temper.

Following this review meeting, I had a discussion with the psychiatrist who referred Brian. She felt that his outbursts at home were not serious and in fact his behaviour was not that unusual. Given that his teacher found him to be settled and making good progress at school, it seemed fair to say that the issues were between Brian and his parents, particularly his mother who perceived his temper to be unacceptable.

It seemed appropriate to involve Brian’s parents in the sessions and we agreed to have four more sessions with Mr and Mrs Thomas joining us for part of each session. The aim of this was to continue to offer Brian some individual time and also to offer him the opportunity to explore different ways of interacting with his parents. I hoped that his mother would be able to see him in a more positive way as she experienced his natural exuberance in a creative setting, focusing on his strengths rather than her perception of him as uncontrollable.

As these four sessions were to form the ending of the work, we decided to meet fortnightly. This also meant that Brian could take part in an after-school football club which seemed an important priority for him at this point.
Brian continued to enjoy the one to one attention he received in the first part of the session. His playing was mostly fast, energetic and loud, but he had also developed a capacity to play quietly and more reflectively. In the penultimate session, Brian rushed upstairs with his bag. His mum said that he had something to show me. He engaged in a series of short improvisations and then rushed to his bag saying that he wanted to show me something. He took out a card that was for his mum for mother’s day. He was keen to know what I thought of the card and I said that he seemed to be very proud of it. He talked expressively and articulately about how important his mum was to him and how he had saved money, nearly £10.00, to buy her something for mother’s day. I suggested that we play a piece of music for his mother and Brian thought that she would like the glockenspiel. He played a gentle melodic improvisation.

It seemed significant that Brian expressed such compassion for his mother, particularly as she seemed to struggle to find positives in his behaviour. He communicated to me how important she was to him and I wondered if the family sessions would present an opportunity for him to share this.

It was particularly useful to share the sessions with Brian’s parents. His mother attended all four sessions and his father was able to attend for two sessions. Both parents engaged and participated fully and we were able
to explore different aspects of communication, such as waiting, listening, taking the lead and sharing. The family seemed relaxed and interacted playfully. In the last two sessions we played an improvisation that involved both playing together as a group and playing individually. Brian decided that his mum could direct this piece. She seemed a little reluctant to do this and expressed concern that she would not be able to. However, she directed the improvisation confidently and the whole piece had a light-hearted and relaxed feel to it. There was a sense of musical cohesion in the rhythm when everyone played together and there was enough space for each person to play individually.

I felt that being in control was perhaps a novel experience for Mrs Thomas and she seemed pleased that she had managed to direct both Brian and his father successfully. When I commented on how well I thought she had done, she explained that it was difficult to be as effective at home. I was able to point out that she had done it here and she appeared to take my comment reassuringly.

Review and Discharge

In a final review meeting at which the out-patient referrer was present, Brian acknowledged that he had become more confident and out-going at school and in general. This was also apparent in his exploration of different musical forms and ways of playing in our sessions. I also pointed out that he had become more flexible in his interactions and did not control
our endings so much. Brian seemed to have used the sessions to express some of his feelings and play out his anxiety and frustration. He appeared to have benefited from the one to one experience, the attention and acceptance given to all his expressions.

In the review, Mrs Thomas stated that things had improved at home, that Brian was listening more and not rushing so much. The psychiatrist commented that Mrs Thomas seemed to feel more in charge to which she agreed. Brian confirmed the change in his behaviour and said he felt more relaxed and able to listen to his mum. It is interesting that this change appeared to have taken place during the last four music therapy sessions, as Mrs Thomas had raised her concerns about Brian’s temper in our first review meeting after four sessions. It seemed that the family sessions had acted as the catalyst for change and I felt it had been important to enable Brian and his parents to spend time having fun together.

Following this review meeting, the referrer felt that the situation had improved significantly and there was no longer any need for input from the CAMHS. Mr and Mrs Thomas agreed with this and felt reassured that the sibling rivalry between Brian and his brothers was normal. They also acknowledged that Brian was making good progress at school despite his stuttering. The case was closed.
Brian had clearly enjoyed attending the music therapy sessions. He responded well to the non-verbal medium that enabled him to have fun interacting. It is interesting that when he did speak in the sessions following improvisation, his stutter was less prominent. This suggested that making music helped him to relax.

The time limited nature of this work, enabled me to take quite a directive approach with Brian. Challenging his playing and helping him to explore other ways of interacting was important in helping him to look at the way in which he reacted in other situations. Brian responded to the opportunity to be playful in the sessions. I feel that his self esteem was increased as a result of experiencing a positive playful relationship where he could express himself freely.

The shared part of the sessions with Mr and Mrs Thomas allowed Brian and his parents the opportunity to explore how they communicate with one another and the elements of control in their relationships. This was done in a playful manner that seemed to be useful in helping them enjoy being together.

The two sessions that Mrs Thomas attended without her husband were significant in that she was able to have some relaxed and warm interactions with Brian. They enjoyed directing each other and seemed to
have found a new, more positive way of being together. I felt that it had been important for Mrs Thomas to spend time with Brian without his siblings around. Making music together enabled her to see his strengths and celebrate the fact that he was different from his brothers.

Again, this piece of work was characterised by clear aims and a positive therapeutic relationship. The involvement and support of Brian’s parents enabled therapeutic change to take place rapidly and appropriately as Brian’s difficulties were placed in the context of the family environment and relationships.
This dissertation has presented the development of the music therapy service at Tanglewood. The range of treatment offered at Tanglewood has been described and a literature review examining short-term treatment approaches was undertaken. Case material was then used to present my approach to music therapy assessment and short-term work.

I would like to conclude with some thoughts and reflections on this model of music therapy. Firstly, I will look at the place of music therapy diagnostic assessment in Tanglewood. Secondly, I will reflect on the case material presented and clarify the approach to short-term music therapy that has emerged from clinical practice. Thirdly, I will consider the possibilities of measuring outcome in this field and suggest why this approach to music therapy seems appropriate in the Child and Adolescent Mental Health Service.

7.1 Music Therapy Diagnostic Assessment

Music Therapy Diagnostic Assessment is a relatively new area for music therapy. This was seen in the literature review, which showed that although music therapists use a variety of assessment procedures, a short assessment for diagnostic purposes is carried out by few therapists. The research by Wigram (1999; 2000) and Oldfield’s current Ph.D research,
are important contributions in this area, developing an evidence-base to which other therapists can refer.

In my experience at Tanglewood, this type of assessment works well within a multi-disciplinary approach to assessment. This was documented in Chapter Four. The case studies described, show how a music therapy assessment can highlight a child’s strengths and difficulties in a unique way. At times, new insights are made into the way in which a child relates or expresses himself. The assessment can provide another tool in helping the team to clarify its thoughts regarding a possible diagnosis, or, as seen in the case of Jeremy, the session might confirm that such a diagnosis was not appropriate. (Jeremy’s presentation changed as he gained confidence in the session. This was seen in the increase in eye contact. This and his spontaneous use of imagination helped to confirm that a diagnosis of Asperger’s syndrome was not appropriate.)

Music therapy assessment is seen as a significant part of Assessment Days at Tanglewood. Wigram and Oldfield have considered the wider implications of this type of work. As Wigram suggests, the next step is to undertake further research to develop and expand the evidence-base. This would include: attention to the detail of the sessions, observations regarding both musical and interpersonal interactions and the contribution to the teams conclusions and recommendations including diagnosis.
7.2 Short-term Music Therapy

The case material presented included short-term music therapy with families and individuals. The approach developed out of clinical practice and was related to my employment being temporary and on short-term contracts. The case of James (Chapter Seven) was significant in that following assessment, my initial feelings were that he would benefit from a longer piece of work. This was not possible and so the number of sessions was planned taking into account the impact of ending and separation for James. I was surprised at James’ progress in such a short time. The intensity of our sessions and the external support that James received all contributed to the positive outcome. Another important factor, I believe, was the feeling by all those involved (James and his family, the consultant psychiatrist, myself and my supervisor) that James could gain something from the sessions. The time-limit seems to have catalysed him into action as he addressed painful and difficult feelings in a constructive way. These difficult feelings were contained both in the music therapy space and externally, by his father and his partner. This experience enabled James to process some of his complex feelings, resulting in a significant and lasting improvement in his behaviour. This was seen in his progress in the ADHD Treatment Group and subsequent discharge from the service.

This case helped to confirm that a short-term model of music therapy with individuals could be appropriate at Tanglewood. When referrals are
received, I ask clinicians to be clear about how they think music therapy might help. This enables me to focus the assessment period on the problem identified, thus helping me to be clear about the aims of further treatment. Not all cases referred are appropriate for short-term work and I have felt frustrated at times by the limitations imposed upon me. The cases that require a more open-ended, long-term approach tend to be those where the development of a therapeutic alliance is more problematic and the child may show resistance to addressing relational and emotional difficulties. These include a small number of children referred who have autistic spectrum disorders for whom music therapy may well be more appropriately provided in their school setting.

Whilst the short-term approach to music therapy with individuals has developed and evolved with my contracts at Tanglewood, this approach with families seemed appropriate from the start. This is possibly because there was already some music therapy literature to support this (Oldfield, 1993). In addition, the work with families initially grew out of referrals to Family Days which is a short therapeutic intervention itself. Following a family’s attendance at Family Days, the team discuss how to proceed with the case. Music therapy is sometimes suggested as an intervention that can offer further insight into the family dynamics or give the family the opportunity of having fun together and re-frame negative relationships. The sessions therefore are clearly focused and the work is supported by the involvement of the case manager.
It has been important to work closely with the referrer in order to hand over the case and enable the family to continue to be supported. Music therapy with families addresses the family system and in so doing, can help to create a more positive environment in which the child can thrive. As stated in the literature regarding therapeutic work with children, the child cannot be seen in isolation. If a healthier environment can be achieved, then the child has a better chance of redressing emotional conflicts.

In the case of Brian, his parents were involved in sessions following individual music therapy. It was felt that Brian’s difficulties were located in his relationship with his parents, his mother in particular. Music therapy was an appropriate place to address these difficulties as it presented an opportunity for the family to be active and explore the ways in which they related to one another.

I would like to suggest that the cases presented share some common features that seem to link with the idea of a model of short-term music therapy. These features are identified at the end of the literature review and I will state them again here:

- A positive therapeutic alliance.
- The active stance of the therapist to encourage the client to focus on and explore the therapeutic focus.
- Containment and structure that is provided by clear boundaries and attention to the therapeutic aims or focus.
• The presence of external support.

I have added the last point about external support, as when reviewing the short-term cases I have worked with, I have found this to be a significant factor in the success of the therapy. It is important for parents to be engaged with the work at Tanglewood. When the child feels supported and experiences containment within the family environment, the outcome of therapeutic intervention is more likely to be positive. The parents may be able to provide this support, though in some cases, it is vital that they too have support from the referring clinician. There have been times when a referral for individual therapy has been postponed due to lack of support from parents.

To give an example of this, in the case of Alex, (Chapter Four) following music therapy assessment, it was felt that he might benefit from further music therapy. However, his external circumstances were not conducive to therapeutic work taking place as his father’s own mental health was unstable and his stepmother was struggling to support the family on her own. It was therefore decided that a referral for individual therapy would not be appropriate until he was in a more stable and supportive environment. In other cases, the therapeutic intervention can even break down if the parents have not been sufficiently engaged and are unable to commit themselves to bringing the child for a series of weekly sessions.
7.3 Short-term Music Therapy within the Child and Adolescent Mental Health Service

This dissertation has used case studies to illustrate the approach to short-term music therapy. Outcome has been measured in relation to the subjective assessment of improvement in sessions as well as reports of improvement externally by case managers, parents and teachers. I have used a basic questionnaire to referrers and parents. The questionnaire asks for parents and referrers to comment on the information received about music therapy, the referral, assessment and review process and finally they are asked to rate how valuable they feel music therapy has been (See Appendix 9). I have not undertaken any formal analysis of the responses. However, in general, feedback has been positive with referrers and parents feeling satisfied with the information received and most feeling completely involved in the review process. On a scale of 1-5, where 1 is not at all valuable and 5 is completely valuable, most parents and referrers rated the value of music therapy as 4 or 5.

The responses to the questionnaire are useful in evaluating the service in terms of referral, assessment and review procedure. The perceived value of music therapy treatment is rated by referrers and parents, however as yet there is no formal process for evaluating outcome following discharge from music therapy or the service. The review procedure would appear to be particularly important in ensuring that all parties feel completely involved in the therapeutic process. The review also allows me to
evaluate a child’s progress and assess the family’s perception of music therapy. If appropriate and if discussed with the child beforehand, some detail of the sessions will be considered, enabling the therapeutic focus to be clarified. This process enables me to form a baseline from which to evaluate any improvement.

Further research into music therapy in this field has recently taken place in Nottingham. Rhian Saville and Esther Mitchell, undertook a pilot project at Thorneywood, CAMHS (Saville and Mitchell, 2000). The project aimed to assess the benefit of music therapy with children and adolescents in this service. A range of questionnaires were used to gauge understanding and awareness of music therapy in staff, to assess the efficacy of the project and to explore the music therapy treatment process. As well as these outcome measures, the project looked at the importance of case studies when assessing the process and efficacy of music therapy. The general findings of the project were that music therapy was viewed positively by the multi-disciplinary team and that staff were keen for the service to continue. Although it was difficult to assess the effect of music therapy for the clients as there were many other factors that might have effected change, the feedback from the questionnaires suggested some positive changes in mood following sessions and a high level of engagement with music therapy.

The music therapy service at Tanglewood is now established as a permanent post. It is hoped that this will lead to research looking at
outcome measures for both short-term music therapy and music therapy diagnostic assessment. The routine use of questionnaires is one method of evaluating the response of parents and referrers to music therapy. The evaluation of case material increases understanding of the therapeutic process and is vital in assessing progress. Finally, the outcome of therapeutic intervention can be evaluated by assessing progress following the end of therapy, though this kind of evaluation can be problematic once a family have left the service.

This dissertation has shown that a model of short-term music therapy seems to be particularly effective in the Child and Adolescent Mental Health Service. There are several reasons why this might be the case:

- Working with the whole family. To refer to Stern (1995), the family is a rapidly developing system. Any therapeutic work has to allow for the natural process of development that takes place within the child and the family. Short-term music therapy that takes place at a time when the family are motivated and supported to make changes, can capitalise on this motivation and allow the family to experience negative relationships in a more positive way. This fits into Stern’s idea of serial brief treatments as described in Chapter Two.
- Involvement and support of family in individual work. The approach at Tanglewood is to involve the whole family in treatment. This means that when individual children are referred for music therapy, the case manager is supporting the parents. This is sometimes reflected in the
music therapy, enabling the child to engage and establish a therapeutic alliance more quickly than if parental support is not present. It is useful to note that staff feel that children who attend groups at Tanglewood are more likely to have a positive outcome if parents have attended the concurrent parents group.

- The medium of music with families. Making music together often represents a new and novel experience for the family. This can help to engage a family, enabling therapeutic change to take place more rapidly. We often find at Tanglewood, that families have become so enmeshed in negative cycles that they have stopped having fun together. The medium of music enables these negative cycles, difficulties with communication and relational problems to be highlighted and addressed in a positive and constructive way with an emphasis on activity and having fun together. This means that the family can be re-engaged with interacting with one another in a positive way.

- The medium of music with children. The importance of play and activity when working with children has been discussed earlier (Chapter Two). At Tanglewood and in the CAMHS generally, it is felt that many children struggle to express themselves verbally. This may be due to complex emotional conflicts that the child is unable to address, developmental problems or difficulties building a relationship. Children are often referred to music therapy at Tanglewood by a clinician who feels that the child needs some sort of individual therapeutic input, but have failed to engage the child on a verbal level.
The use of music is often more accessible than verbal therapies, enabling children to access and work with their emotions more effectively. In addition, for those children who are unable to think about their emotions at all, music therapy can offer a non-threatening and playful experience that focuses on building confidence and self-esteem and a positive relationship with the therapist, before beginning to address emotions.


Appendix 1

Tanglewood Leaflet (draft version)
Appendix 2

Assessment Days programme, information sheet and Aims and Objectives of group and individual sessions
Appendix 3

Family Assessment Programme
Appendix 4

Family Days programme and information sheet
Appendix 5

ADHD Group information sheet
Appendix 6

Social Skills Group information sheet and parents’ letter
Appendix 8

Music Therapy Group information letter for parents
Appendix 9

Music Therapy Questionnaire