

*Maintaining dialogue -
active music therapy for
people living with Multiple
Sclerosis*

Schmid, Wolfgang

Introduction

In this paper I will present you some of my practical work from the controlled study „Active Music Therapy for people living with Multiple Sclerosis“, which I in a team consisting of a doctor, a nurse, a statistician and under supervision of David Aldridge.

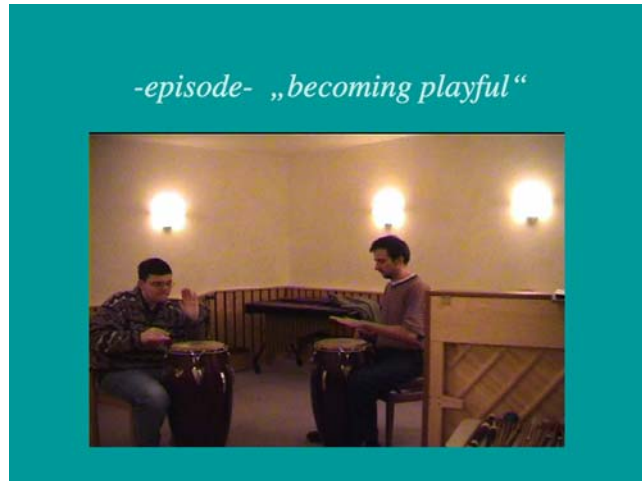
VIDEO EPISODE 1

I start with a video-episode out of this project. It shows the therapeutic situation as it is representative for my work with patient and therapist improvising music.

In this episode we both play on congas. The patient knows the instrument and he plays it in a characteristic way, without pauses and with many changes in his rhythmic ideas. He seems to be very concentrated on his own playing and the coordination of his hands. In fact he has a medium ataxia in his arms with problems to coordinate them.

I accompany him in different modes: first I try to follow him, then I start to use pauses and play more impulsive rolls on my drum. This attracts his attention to me as a fellow musician and his playing changes.

FIGURE 1. Episode “becoming playful”



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As you could hear and see, there were different levels of contact and interaction in this episode.

In my qualitative analysis of all music therapy sessions I identified the individual interaction and contact between patient and therapist as the core-construct for the therapy-course and most important for the changes in therapy. I will come back later to this idea, and continue with some informations about MS, as well as the needs of the patients for complementary and alternative therapies. Then I will present you the findings of my study, showing some quantitative results and the results of my qualitative evaluation, illustrating them with some video-episodes out of the project.

Background

Multiple Sclerosis is the most frequent inflammatory disease of the central nervous system among young adults. There is an estimated number of 2,5 million people with MS worldwide. A major fact, patients and therapists are confronted with is, that MS is a degenerative disease and there is no cure. MS causes a variety of symptoms and complex constellations of symptoms, which can affect each area of human life. Main symptoms are fatigue (a special kind of tiredness), sensory, motor and speech problems. The origins of the disease have been intensively researched in the last decade and it became possible to influence the progress of the disease with medication to some degree.

While medical approaches undoubtedly focus on a functional strategy for treatment, we cannot ignore that diseases like MS have also implications for the performance and appearance of a person in everyday life. As there are no curative treatments, we are reliant on medical as well as on palliative interventions and rehabilitation. The frequently life-long process of coping, that begins with the diagnosis of MS, requires continuous efforts to adapt to changing situations and obviously demands a range of therapies which must also consider and encourage a patient's creative abilities.

According to recent publications, MS-patients are expressing increasing interest in alternative and complementary therapies. One reason for this is that the patients want to play a more active role in coping with the disease. Another reason is the demand for a wider range of therapies to meet social and emotional needs and for mental health in general.

In my research for literature I found five studies about music therapy with MS-patients (Alcock, 2001; Magee, 2002; Rothwell, 1997; Schmidt, 1998; Springer, 2001; Wiens, 1999).

Four with qualitative, one with a quantitative design. They all have clinical, but different backgrounds and show the benefits of music therapy in giving patients a chance to become active, to become creative, and supporting them in their coping process by singing and composing songs. Only the quantitative study from Wiens et al. (1999) has a controlled design, showing that a special programme with singing and breathing improves the respiratory muscle strength in patients with advanced multiple sclerosis.

THE STUDY

In my controlled study twenty patients (14 female, 6 male) with MS were involved. Their ages ranged from 29 to 47 years, and with an average disease duration of 11 years. Ten participants formed the therapy group and ten the control group. The groups included patients with minimal disability signs as well as patients with disability impairing full daily activities. The therapy group got three blocks of 8-10 individual sessions of active music therapy (Nordoff/Robbins approach) over the course of one year. Exclusion criteria were pregnancy and mental disorders requiring medication. The protection of data privacy and the ethical aspects were examined and approved by the Ethic Committee of the University of Witten/Herdecke.

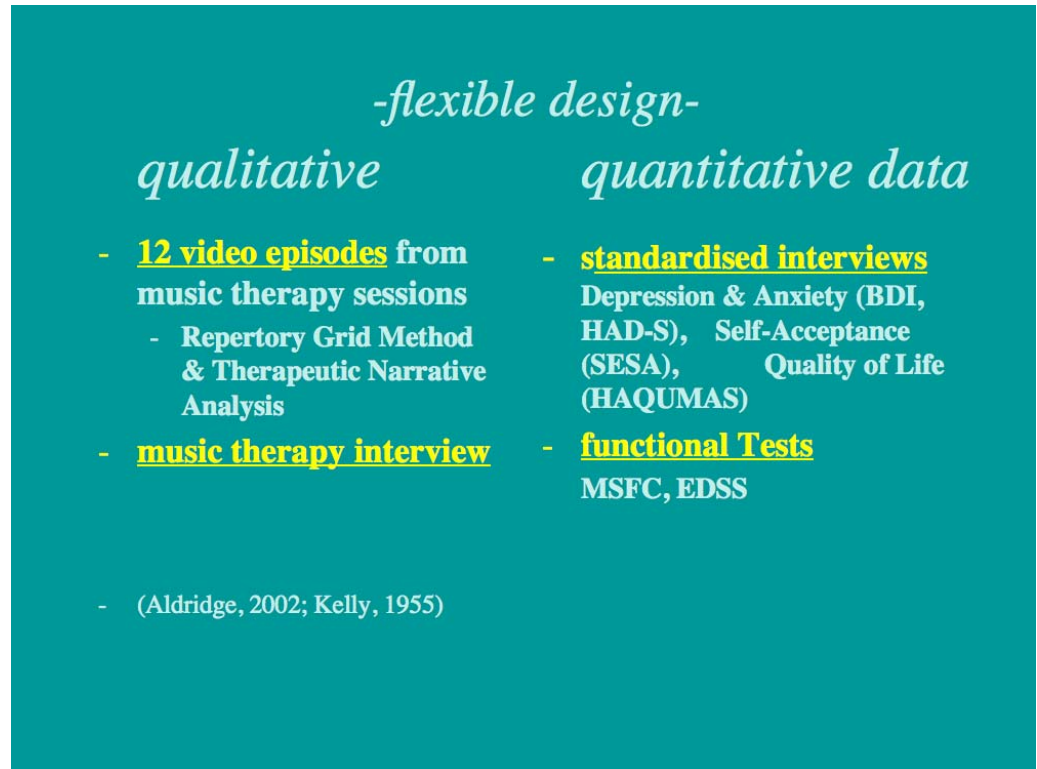
Aims

The main questions for the study were:

- What kind of specific support MS-patients can gain from Active Music Therapy?
- Which changes can be discovered in standardised interviews?

Method

FIGURE 2. Flexible design

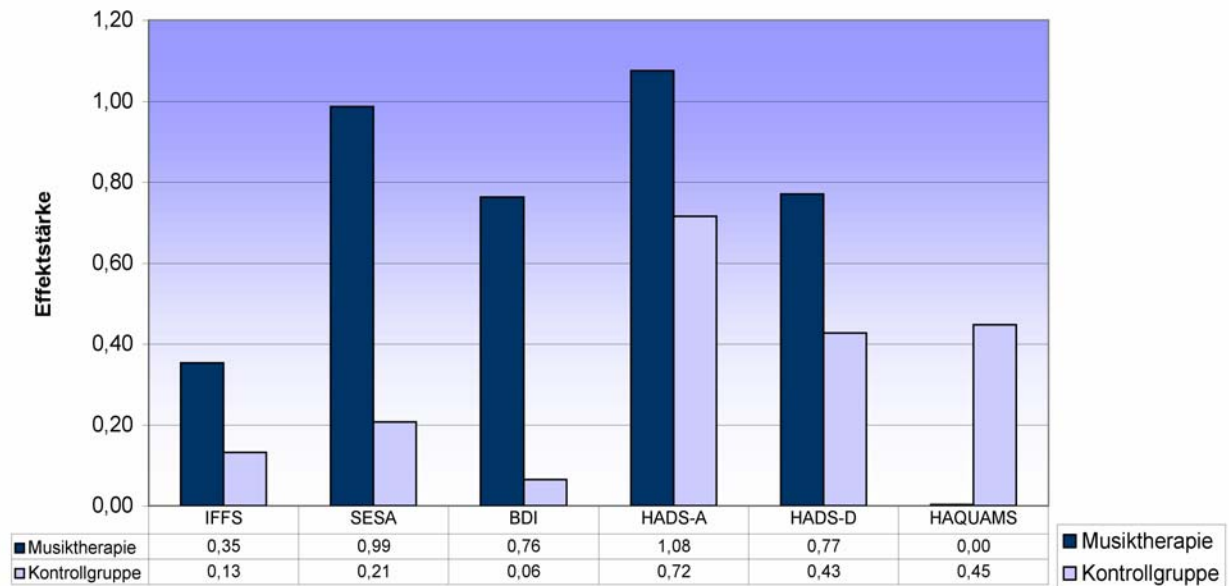


Therefore we implemented a flexible design for the study, collecting qualitative and quantitative data. This data consisted of video episodes from the music therapy sessions. And a music therapy interview, asking participants about their experiences with music therapy.

Both groups were interviewed with a neuropsychological test battery and psychological interviews before therapy began and at three months intervals.

Results

FIGURE 3.



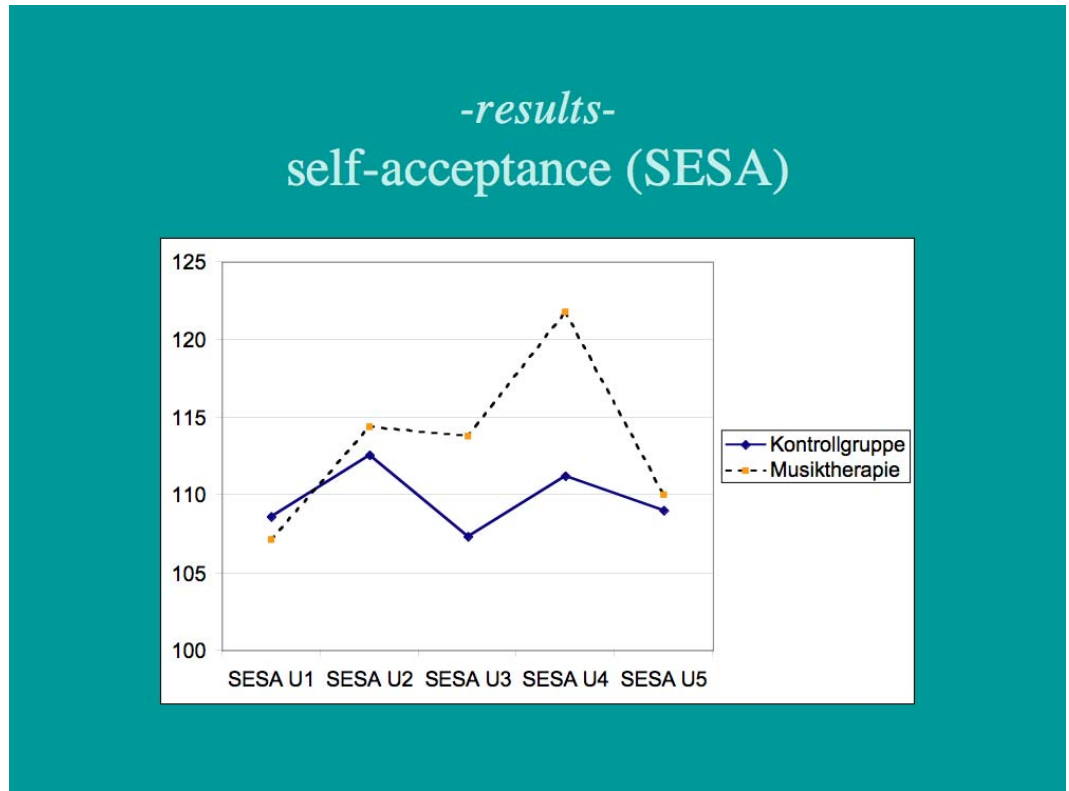
STANDARDISED INTERVIEWS AND TESTS:

At the start of the study and at the final assessment stage one year later there were no significant differences between the music therapy group and the control group. But improvements were found for the therapy group over time in the scale values of self-acceptance, depression and anxiety. This improvements can be compared as effect sizes (shown here: dark blue: therapy-group; light blue: control-group). Here we see a considerable effect between the beginning and the end of the therapy on improving self-esteem and relieving depression and anxiety for the people of the music therapy group. Only minimal improvements were found in the subscale „communication“ of the quality of life scale. In both groups there were no recognizable changes in motor and functional abilities.

So we could say, that the form of Creative music therapy used here is valuable for promoting a positive self identity and relieving the emo-

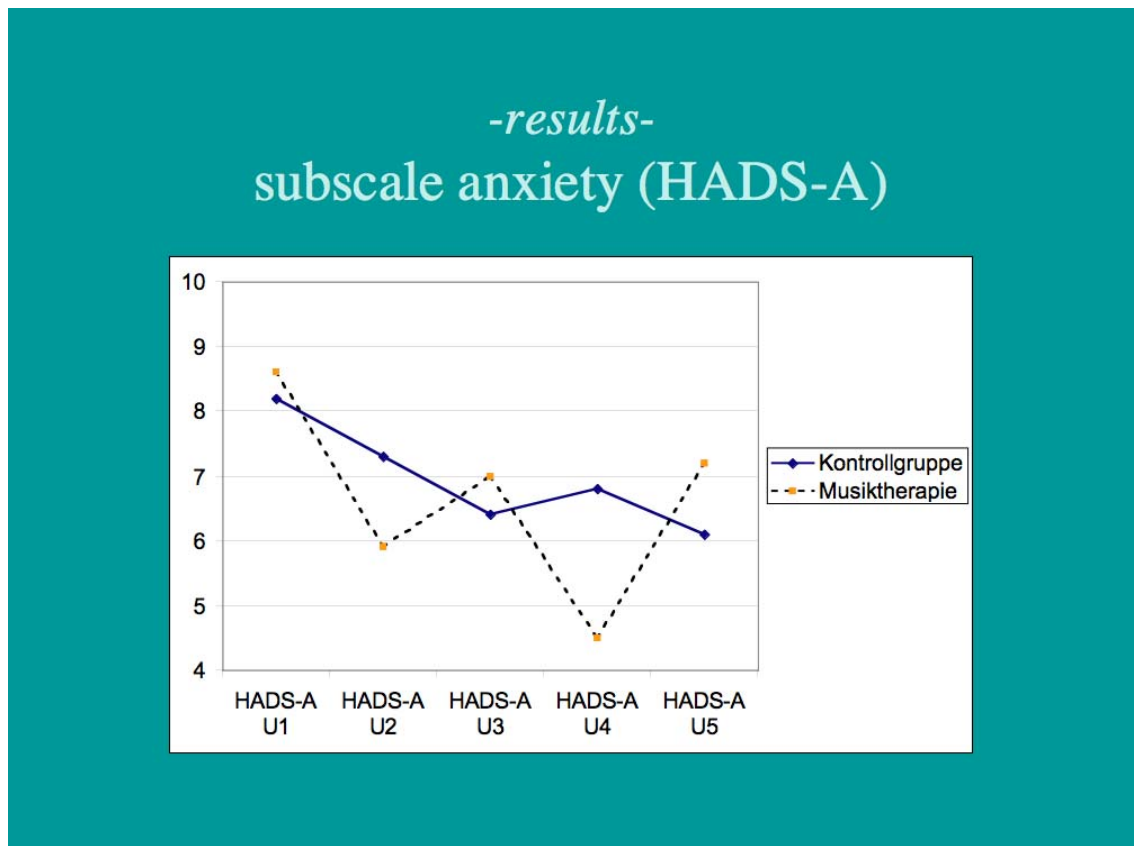
tional burden on a patient. Other music therapy approaches may focus different subjects.

FIGURE 4. Self - acceptance (SESA)



The scale of self-acceptance shows a significant effect for the therapy group in self-acceptance, which is comparable to the normal population (the control group is shown in blue, music therapy group is shown in orange).

FIGURE 5. Subscale anxiety (HADS-A)



Significant differences were found for the therapy group and for the control group in the subscale anxiety of the HADS, while the values of the control for depression and self-acceptance did not show any differences over time.

This may be an indication that being recruited for a trial and being regularly assessed is perhaps in itself an important intervention for this group.

QUALITATIVE EVALUATION

I selected 37 video-episodes from the 226 sessions, showing characteristic situations of therapeutic change, which I found in a process of analysing (that means looking at and listening to them) and in discussions with my supervisor David Aldridge. The episodes were evaluated by Kellys

Repertory Grid Method and the Therapeutic Narrative Analysis, finding categories for what happens in music therapy.

A main result, the main categorie and core-construct of the qualitative evaluation is the individual contact between MS- patient and therapist in music therapy.

9 parameters for contact in music therapy. To describe this contact more in detail, I found 9 sub-categories, I call them parameters for contact in music therapy. These parameters are.:

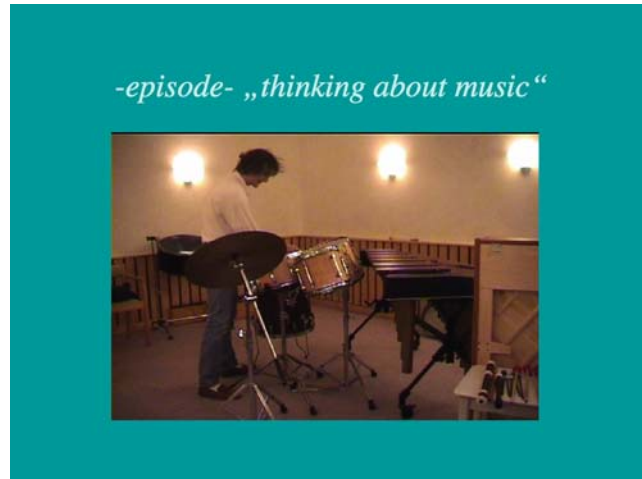
1. „attitude of patient and therapist towards therapeutic situation“, that is e.g. do we play or do we exercise and work in music therapy ?
2. „the idea for joint music making“, e.g. a melodic motif, a mental image.
3. „The question if we improvise or play or sing a composed piece of music
4. „the material for music making: e.g the choice of instrument or the voice“
5. „the musical roles of patient and therapist“ (this is e.g.the question who leads and who follows?).
6. „the ability to structure time“
7. „the ability to initiate changes in play“
8. For this we have „the dynamic elements of music“
9. „movement“ which represents all signs of non-verbal body-language: is there bodily movement or not, is there eye-contact or not.

When I start to describe an episode in terms of this parameters for contact, I see that it is not only one parameter per episode, but two or more parameters that are connected with each other.

In the next episode with he title „thinking about music“ the parameters „attitude towards the situation“, the clearness of the „musical roles“ and the „temporal strucure“ are important for the contact, they are connected with each other and can be used to explain the interaction.

The episode shows the beginning of our playing: the patient has decided to play four drums in the same sequence. You hear what happens, when I try to follow his idea tone for tone, and what happens, when a clear Metrum and Tempo are introduced into the music.

FIGURE 6. Episode “thinking about music”

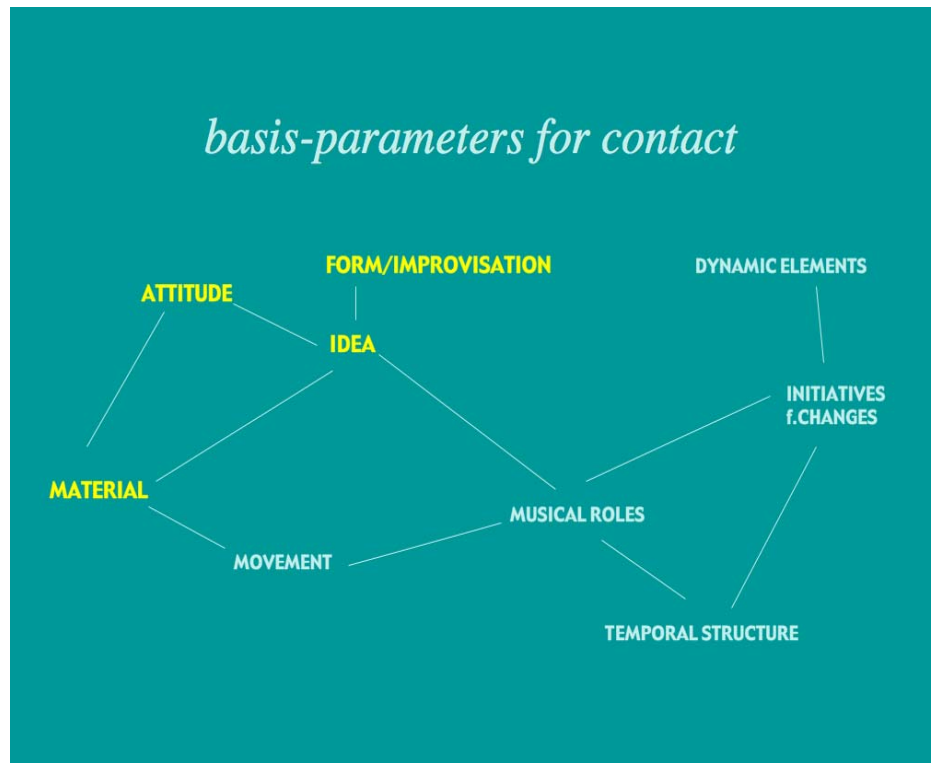


[Download video 2](#)

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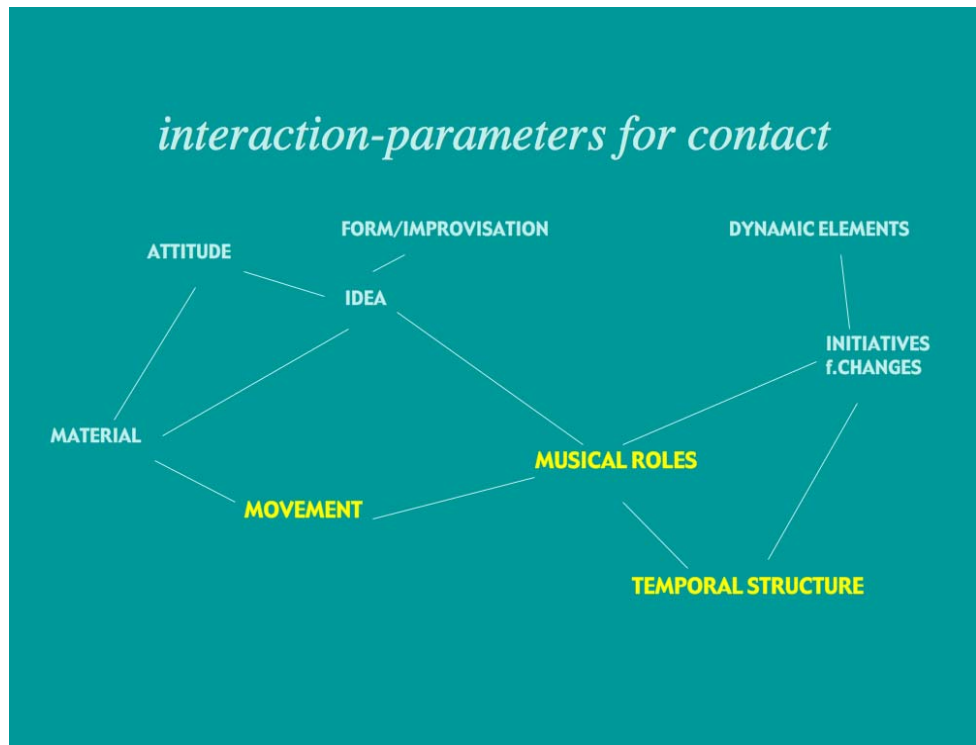
This episode as well as the others show, that parameters for contact are connected with each other and occur together in groups. This groups have dynamic qualities depending on how they are related to each other in various situations. Although I found no hierarchy in the parameter system, I can fix three groups of parameters.

FIGURE 7. Basis parameters for contact - 1



There are the three basis-parameters: „attitude towards therapeutic situation“, the „idea for joint music making“ and the „material“. Basis-parameters stand for conscious or unconscious decisions of patient and therapist for the joint music making. They are a kind of frame for the music therapy sessions. As all parameters their properties can change and lead to another quality of contact.

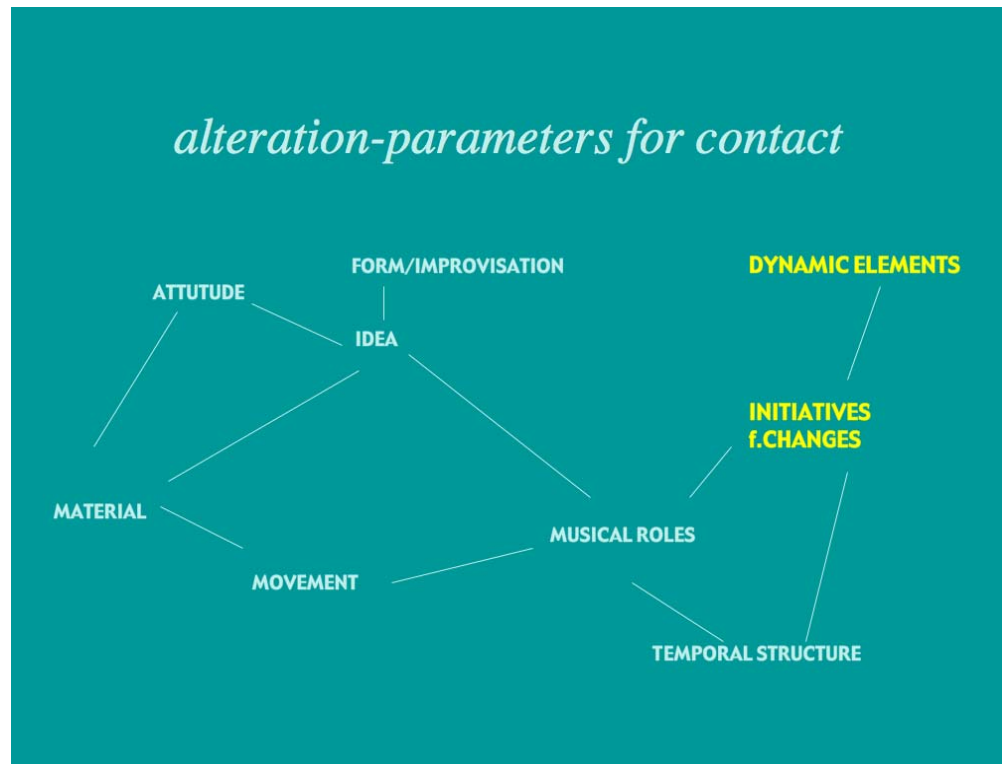
FIGURE 8. Basis parameters for contact - 2



Beside the basis-parameters there are three interaction-parameters.

1. First is „movement“ which stands for all aspects of non-verbal communication like body-movements, gesture or mimic.
2. Second is the „musical roles“: I found that it is very important in music therapy with MS-patients, to help them to find a clear musical role, as we have it in a song for example. : singer and accompanist.
3. The third interaction-parameter is „temporal structure“, which means, that the ability to structure time gives both players or singers a reliable temporal ground for their interaction.

FIGURE 9. Basis parameters for contact - 2



Last but not least there are two alteration-parameters, which stand for changes in music like ritardando or accelerando but also for changes in style or mood of music.

Phases of contact. This three groups of parameters follow each other and can be described as phases for contact in active music therapy with MS-patients.

1. First phase is „exploration“: where patient and therapist become active. Within his activity the patient can orientate himself.
2. The second phase is „interaction“: here a bodily experience comes into music; the patient integrates his body-movements into his musical expression. His body-expressions become part of the encounter.
3. The third phase is „development“: in which the expressive repertoire of both, patient and therapist, develops and both find in a new balance.

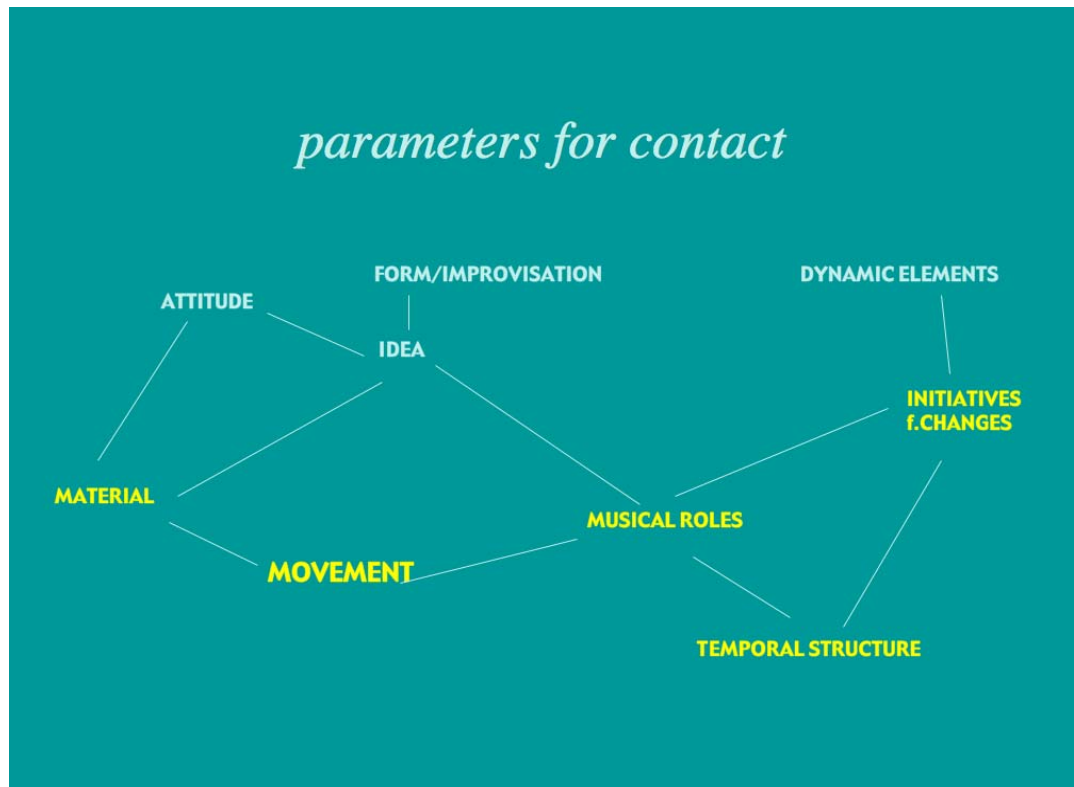
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I would like to play some more episodes to you, focussing the second phase of contact „Interaction“ with coordination and bodily experience in music therapy interaction.

I found that active joint music making supports patients bodily experience as well as the expressive repertoire of their bodies.

FIGURE 10.

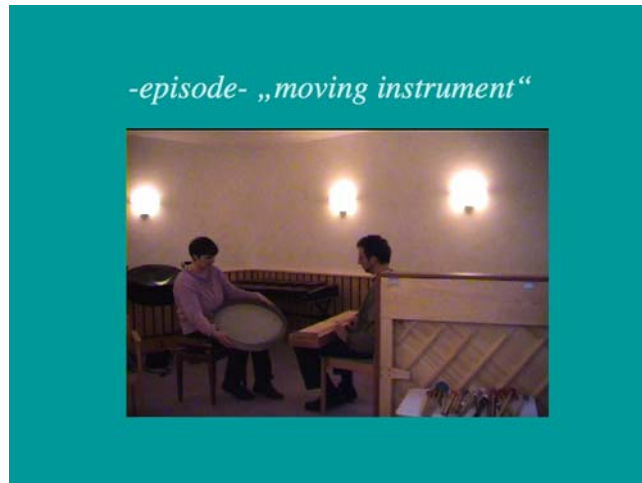


This happens in many individual ways and is shown in the parameter grafik. „Movement“ can be supported by

- MATERIAL: Instruments which have sounding qualities like gongs, the steel-drum etc. in contrast to rhythmic instruments
- singing songs as well as improvising
- MUSICAL ROLES and TEMPORAL STRUCTURE: By playing in an alternating, dialogic mode, which challenges both players
- A moving instrument, as it can be seen in the next episode.

In the episode „moving instrument“ the patient is interested in the sound and movements of the ‚ocean drum‘. She says that the instrument makes movements she cannot do any more. I play with her, but also just listen to her playing. The episode is an example for how a patient needs time to come into contact with her own playing.

FIGURE 11. Episode “moving instrument”

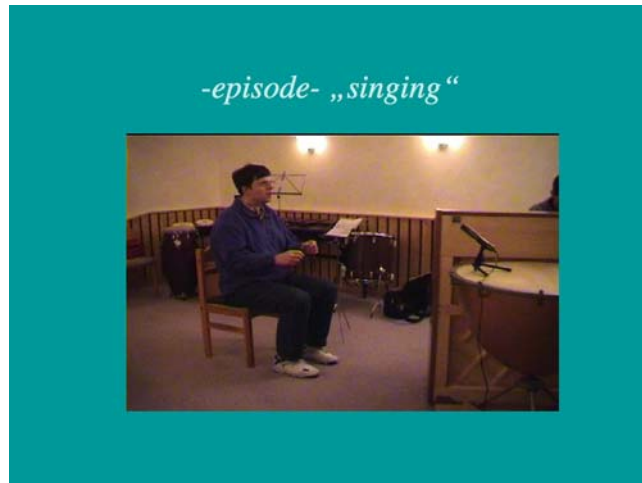


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The episode „singing“ is from the patient you saw before with the conga. He sings freely and brave for his first time in therapy. With his voice as „material“, he is independent from motor functioning and establishes a slow and flexible tempo with rubatos. The music is enlivened by growing tension and relaxation. He seems to enjoy it and there is room for emotional expression and sense of tone in the music.

FIGURE 12. Episode “singing”

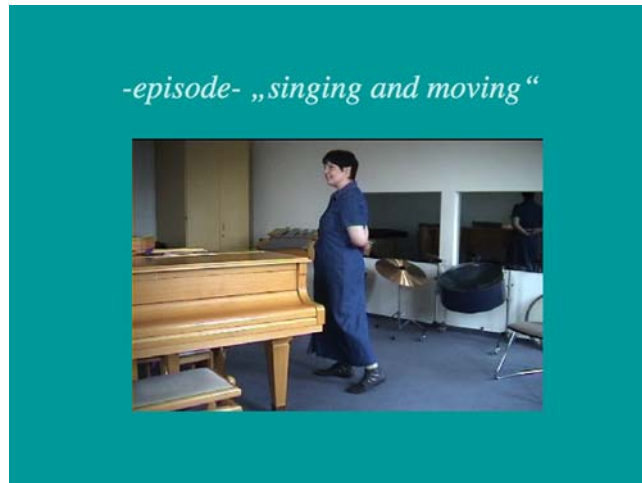


[Download video 4](#)

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For some patients it is not as naturally to sing. One idea was, to combine body movements and singing. This can be seen in the next episode. The patient was too shy for just singing, so we started to walk through the therapy room, I started to make sounds with my voice in our walking tempo, and the patients was able to join in. You see, how she moves and even starts to dance.

FIGURE 13. Episode “playing and singing”

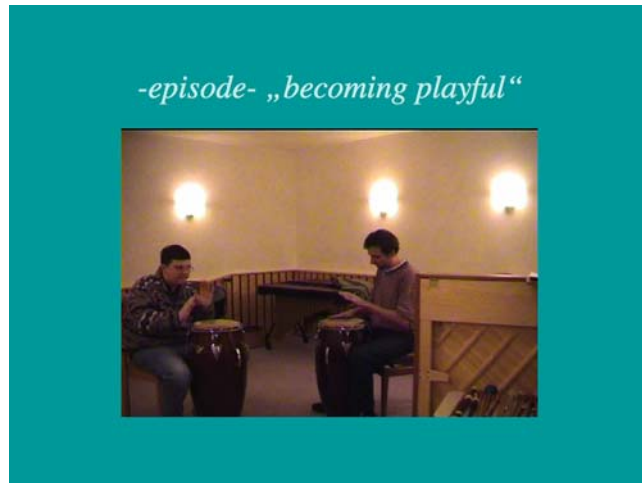


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Bodily experience in active music therapy is also connected with the „musical roles“ and „initiatives for changes“ as you saw it in the first episode. I'll play it again now. Please notice the sequence after we change our mode from playing simulanenously to an alternating, dialogic one, the patient involves his body more into his playing.

FIGURE 14. Episode “becoming playful”

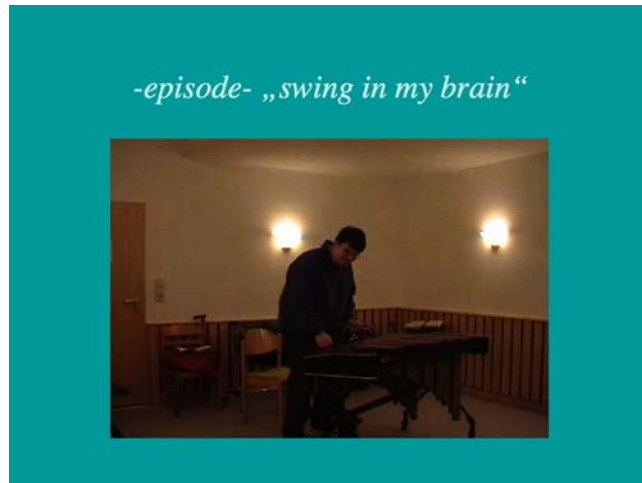


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The last episode is from the same patient; it's out of his 10th session and shows, how he transfers his experiences from singing to his playing on a marimbaphone. His attitude and his idea about playing an instrument changed completely. He communicates with body movements and with an initiative and dynamic playing. He titled this improvisation: „Swing in my brain“.

FIGURE 15. Episode “Swing in my brain”



[Download video](#)

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Summary

To summarize, I would like to quote from the music therapy interviews, what the patients said about their music therapy experience.

Nine out of ten participants described that it was very important for them to become personally active.

All ten participants reported an immediate improvement in their well-being during the sessions. For eight of them this state continued till the next day and was confirmed by partners or colleagues.

Seven participants described an enhanced perception of themselves with an increasing self-confidence over the course of the therapy. They were increasingly able to let themselves be surprised by their music and by their own previously undiscovered skills.

Music and music therapy are experienced as „something moving“ that reduces negative thoughts about the disease and offers a means of expression for feelings of security, freedom and pleasure.

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