A Conversation About... Mental Health and Music Therapy: Therapeutic Outcomes

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Host (00:01):

Hi there. Welcome to Mental Health Professionals Network podcast series MHPN's aim is to promote and celebrate interdisciplinary collaborative mental health care.

Professor Mark Creamer (00:18):

Hello, and welcome to this episode of MHPN Presents, A Conversation About mental health and the arts. This is a podcast series that explores the relationship between mental health and psychological wellbeing on the one hand, and artistic involvement and expression on the other. So during this series, I'll be joined by researchers, by creative arts therapists, by mental health clinicians, and also by artists of various kinds who have an interest in mental health and perhaps who have experienced mental health issues themselves. And together these people will help us explore this relationship between our involvement as a creator or an observer of artistic expression and our psychological health and wellbeing. And we'll try and touch on both the positive and potential negative impacts of these relationships. My name's Mark, Mark Creamer. I made clinical psychologist and professorial fellow in the Department of Psychiatry at the University of Melbourne.

(01:18):

And I'm delighted to be hosting this series because I'm very interested, of course, in mental health and how we might help people with mental health problems. But I've got a particular interest in this three episode miniseries, as it were, where we're talking about music therapy because I am very keen on music. I must say that in the introductions to the last couple of episodes, I've already revealed more of myself than I normally would because I'm not big on boundaries. But suffice to say that I love music and I'm sure that it's very good for my mental health. So I am really thrilled to welcome back our two very experienced music therapists, Jen Bibb and Jason Kenner, who are joining us today for the final of our

three episodes on music therapy. Welcome Jen. Thanks for joining us. Can I just get you to perhaps just do a sentence on where you are in your work?

Dr Jennifer Bibb (02:10):

Sure. So I'm a registered music therapist and have experience working in mental health settings primarily over the last 10 years. I'm also a researcher and I'm currently working as a researcher at the Alive National Centre for Mental Health Research Translation at the University of Melbourne.

Professor Mark Creamer (02:26):

Lovely, thanks and welcome to you Jason again. Can you just give us a potted quick summary?

Dr Jason Kenner (02:31):

Thanks, Mark. Yes, so I'm also a registered music therapist and I'm currently in private practise at Melbourne Music Therapy. And I've got a group of therapists that work for me. We do a lot of NDIS work, but we also do work in schools, aged care hospitals and more.

Professor Mark Creamer (02:48):

Right, perfect. Thank you very much. So you both bring a wealth of experience to this topic and it's great to have you. Now in our first episode, Jen and Jason, you talked about your, to where you are today, your pathway into music therapy. In the second you told us about your favourite types of music. So today I want to put you on the spot and I'm very interested to know what if any types of music you don't like. And actually when I say if any, you're not allowed to say none. I like all kinds of music. So what kinds of music, what genres perhaps or types of music would you say that you don't particularly like?

Dr Jennifer Bibb (03:22):

So for me, I suppose something I'm not too keen on, and some of it is quite contemporary today, I think of the speaking rather than singing along to the background music. I just can't stand that. I just want people to sing if they're going to have their voice on there, just sing. Yeah. So that's probably it for me, my kind of pet hate.

Professor Mark Creamer (03:41):

But you are okay with hip hop and ...

Dr Jennifer Bibb (03:43):

Yeah, because it's got the rhythm.

Professor Mark Creamer (03:45):

The rhythm. Of course. Of course. Fair enough.

Dr Jennifer Bibb (03:47):

So in a way that is kind of singing in a way because it does have the rhythm, but when it's just speaking over music. Yeah, not taken.

Professor Mark Creamer (03:55):

Fair enough. Fair enough. What about you Jason?

Dr Jason Kenner (03:58):

I just struggle with really offensive lyrics. I just can't cope with that very well. Maybe I'm getting a bit old, but that's probably the thing that I can't deal with so well, I'm also not a huge fan of the Disney stuff. A lot of people really love it, so some people might turn off right now, but yeah, I'm not that into that stuff.

Professor Mark Creamer (04:19):

We are not going to be playing any fair enough, too. Fair enough too. And I wonder, this is a philosophical question that we'll just touch on briefly. It is about this idea about whether you can actually describe music or indeed any other art form as being good or bad. Can I say this is good music and that's bad music? Or is it intrinsic? It's just art. It's neither good nor bad.

Dr Jason Kenner (04:41):

I think you have to define music first and then maybe you can use that definition as a way of then saying what is good or bad according to that definition. But I don't really think that I can objectively say that something is bad music. I could be a snob and say that maybe the music is played badly and that someone isn't very good. But still, I don't think I've got the right to do that either. And I think from a music therapy perspective, as we were saying in the previous episode as well, that there's no good or bad music in terms of what makes us better or worse,

Professor Mark Creamer (05:16):

It is just people's personal preference and we know that it's different for everyone. So what might work for somebody and what might make them feel great will be very different to another person. Yes, absolutely. I have to say though that I was guilty certainly in my younger years of being somewhat superior and saying that's rubbish, that commercial rubbish Abba will be a good example who I now come to recognise even though I might not be a great fan of their music, very, very extraordinarily talented people. Of course. Yeah, of course. So in our first episode in this three-part series, Jason and Jen gave us an introduction, a kind of overview to the field of music therapy. And in the second episode we learned in detail about what actually happens in a music therapy session and also who it's for. And if you haven't listened to either of those two episodes, I strongly encourage you to go back and listen to those first two.

(06:09):

But in this final episode, I really want to talk about what music therapy aims to achieve, I suppose, what our treatment goals are, what it is that we and our clients are hoping to achieve from it. And I'd also then like to go on and talk about whether we understand what's going on in terms of mechanisms or explanatory models. We'll talk a bit about multidisciplinary teams and so on. So we've got a lot to get through. We'll work fast though, Jen, let me throw it to you. And you actually touched on this, I think in the last episode you talked about quality of life as being a legitimate outcome, which I a hundred percent agree, but what sort of treatment goals might you have for music therapy?

Dr Jennifer Bibb (06:45):

So again, I think it depends on the person's needs, who you're working with, what the goals were that you kind of set together and you're collaborating on and why you're working together. I think some

examples of some outcomes might be shorter kind of term or longer term. So for someone for example, in a mental health setting who has come to you or has been referred for emotional regulation or kind of expressing emotions and learning about that kind of part of things for them, it could be that in a music therapy session you use some active music therapy methods where you are writing a song with them in order to help them to process some trauma or what's been going on for them or what's happening for them in a session, which immediately I guess might make them feel better afterwards from having expressed those kinds of things.

(07:36):

But also then longer term we think of after a series of going to music therapy every week or whatever it is for that person depending on their needs, some of the outcomes that you could have, we were talking about in the last episode about playlist creation and supporting mental health through that. So it could be that someone comes to a music therapy session each week and learns about intentionally using music to support their wellbeing. And perhaps in between sessions over a longer term period of time, they start to practice, okay, I am feeling really anxious. I've got this coming up, this is what I'm feeling. I'm putting on this playlist to try and help me intentionally feel better.

Professor Mark Creamer (08:20):

So you're giving them a skill that they can take away, in fact to coping mechanism. Coping strategy.

Dr Jennifer Bibb (08:25):

Absolutely. Yeah. And then longer term it becomes another kind of tool that they have in their tool belt for promoting their mental health. And sometimes people that I've worked with in the past, it's been at first just five minutes, I was working with someone with an eating disorder a few years ago and they described that putting on that song that we talked about so much or that playlist for them was like a circuit breaker between the thoughts. It was just started off with being five minutes of just I don't have to think about all of this stuff that is going on in my head all the time. And that kind of just broke that circuit so that then they could go on and do something else or call a friend or something like that. And then hopefully in time it builds and builds and becomes a really healthy kind of protein.

Professor Mark Creamer (09:15):

Absolutely, absolutely. I think it's quite important to differentiate between what can make someone feel better and what can make someone get better. And both are very important. I wouldn't dismiss either, but we need to understand the difference. But you are saying here, not only does music therapy have the potential to make someone feel better, which is great, but also in fact these are skills that they can take away and that teach them how to cope better with triggers or difficult situations in their future. So yeah, I do want to come back to this quality of life thing because I think in my training the emphasis was very much on symptom reduction. Can you reduce the symptoms? Very important, not backing away from it, but actually there's a whole area of functioning social and occupational functioning that it's really important that we didn't give much attention to. And this broader concept of quality of life generally, even if symptoms necessarily haven't dropped a huge amount, nevertheless, quality of life. So would that be legitimate outcome for music therapy across the board?

Dr Jason Kenner (10:11):

Yeah, definitely. In the work that we do, I talk to people at the very beginning and this is a part of the conversation along the way. This is particularly in a mental health context, so just want to emphasise

that we don't only work in mental health, we do lots of other types of rehab, which is a bit more functional, but in mental health I like to think of what I'm doing as a collaboration with the person that I'm working with. And so I'm bringing my expertise as a music therapist in, they're bringing their expertise on who they are and what they know about themselves. I don't know them as well as they do. They're the expert on that. And so what we then do is we start working together in a collaborative way and then there's this opportunity to start working on some of these skills like negotiating, listening, dealing with not always getting your way or being a bit more assertive at times.

(11:00):

So there's always this opportunity to work on a lot of these really important skills that everybody needs to do things like return to work or be a better parent or whatever's going on for them. And we do it in the context of music projects often. So we're writing a song, maybe then recording it, or we're just working on some music skills and practising playing music together, or we're just learning to improvise together. So what we're trying to do is we're trying to help the participant that we're working with experience themselves relationally with the lessening emotional intensity. Because often the challenges for people are about the responses they have emotionally to what happens interpersonally with another person if they feel some sort of disconnect or something hasn't gone quite to plan or they're worried about what somebody's thinking of them. And there's a lot of judgement in that. So trying to then unpack what's going on when you notice these little ruptures in the relationship and you can talk about them in a fairly safe way because the stakes aren't really quite so high when we're talking about a music project, there's still lots of opportunities to redo it or change it. It's a bit safer and a bit easier than maybe some of the other times when these things get in the way in the rest of their life.

Professor Mark Creamer (12:18):

And so I was going to ask about how important is it to formulate the case to understand where the person's coming from to understand why they've reached this point when they're sitting in front of you kind of thing. But it sounds like that is fairly important in each individual case.

Dr Jennifer Bibb (12:33):

Absolutely, yeah, it's so important. Yeah. So we go through a process of assessing the person's needs when we meet them, formulating goals, a plan using particular music therapy methods, and then a process of evaluation and going back through that cycle. Okay, how are we going? What's the plan forward?

Professor Mark Creamer (12:53):

Yes, okay, so it's certainly not this person's depressed, so we use this, this person's got PTSD, so we use this. No, it's very much individually tailored.

Dr Jason Kenner (13:02):

And that's what I think our profession varies from some related professions like say sound therapy where they use particular tones or focusing on certain types of sounds that might be prescribed as affecting somebody in a particular way. And they could be linked to things like chakras and this kind of stuff, which is great for people that are into that, but that's not what we do. So it's not prescriptive in that way at all.

(13:29):

We don't think of music that way. And sometimes people come into our sessions and they think that music has these kind of magical properties that can do things like change them, but we need to kind of be careful around that because there isn't really any evidence to support that particular tones will affect your body in certain ways. It's always good to be able to just sit and relax and listen. That's absolutely beneficial, but we don't have a prescriptive way of thinking about this. Music will do this to everybody.

Professor Mark Creamer (14:00):

I have to say I've never even heard of sound therapy,

(14:03):

But I think probably we won't go down that anyway, just be on the safe side there. But I'm interested that there is such a thing, and I take your point of course about the importance of formulating the case or understanding where the person's coming from, but sometimes as you've said, you're actually working in groups, you presumably don't necessarily have time to assess every individual and sometimes you have to make a decision perhaps about the status of the group, the dynamics of the group. Just talk a little bit about when you're working with a group of school children or a group of patients in a psychiatric hospital.

Dr Jason Kenner (14:32):

Yeah, I've done a lot of group work and it was all I did actually for a certain period of time was only working groups. And so we often work with those natural group dynamics and how they change over time and try to leverage that in the way that we work with a group. You'd need to be aware of what's going on with everyone in the space. You also need sometimes a way of being able to manage that group process is to design a group and then have some sort of process around to who do you invite in the group. So it's kind of like a reverse assessment thing rather than as assess someone and then design something for them. You design something and then you make sure you invite the people that are the right people for the group. So that's another way of dealing with that too.

Dr Jennifer Bibb (15:19):

And I think too, a really good way of managing this, and I know a lot of allied health professions do this as well, is that when you starting off with a group, you set the collaborate on what are we wanting to achieve, what are the rules or the kind of principles for the group that we're all going to adhere to? And then you keep bringing it back to that stuff and we're all here to achieve this or we're all here to do this.

Professor Mark Creamer (15:42):

Absolutely. I think there's so much misunderstanding about groups. I think sometimes people think groups are dead easy. You just go in there and run it. Actually groups are incredibly difficult to run well, they you really need to be on the ball.

Dr Jason Kenner (15:52):

Definitely. But they have huge potential. And in this current climate with the NDIS where most people just do individual work, it's quite difficult as a practitioner in that space. You can create groups, but it's not as easy. So I think there's probably not as many groups going on as there could be and possibly should be because the potential in a group is sometimes superior to one-on-one.

Professor Mark Creamer (16:19):

And especially as I think we were talking about in the first episode when we were trying to define music, we talked about how important the shared experience is in a group, of course is presumably a great way to do that. I wonder if we could move on and talk a little bit about what we know or what we think about what's going on in music therapy, whether we have any explanatory models to explain the mechanisms of change.

Dr Jason Kenner (16:41):

So we do have some models. It's very hard to really prove these things because we're talking about changes in the brain. And as you would know in psychology, it's difficult as well. I mean you can find evidence for particular ways of working, but you can't really find evidence for the mechanisms that are happening on the brain level. But you do have theories and of course they're based primarily on brain plasticity. We believe that people can change. We know people can change. So what are the things that we can do that help to support change? So we want to try and provide experiences that people can participate in that are maybe challenging some of their preconceived ways of being. So going back to that emotionality that I mentioned earlier, and there's often a lot of judgement that goes on that's behind that. This is not a technique that's specific to music therapy.

(17:38):

It's used in DBT as well where you try to use non-judgmental evaluation. And so that's something that we can do in music because it's very easy as particularly when you're young, when you're a teenager that music's terrible or that music's great. So we will often do things, I do things with some of the participants that I work with where we listen to music and we try to just describe it without any judgement at all. No judgement words. You might feel judgement , but you're not allowed to use those words. It's usually a written exercise. And so what that forces someone to do is to just go that next level and ask themselves, well, why don't I like that? What's going on? What's it making me think about? So what we're doing is we're practising ways of analysing and taking the emotional heat out of it and just being able to then reflect.

Professor Mark Creamer (18:29):

That's very interesting. I know you mentioned DBT, just for the benefit of our listeners who may not have heard of it, dialectical behaviour therapy specifically designed for working with borderlines. The comment you make there about analysing the music I think is fascinating and being able to label it because part of DBT, of course is teaching people to label their feelings, isn't it? Putting words to emotions and so on, which sometimes people are not very good at. So that's a great analogy for that process, isn't it,

Dr Jason Kenner (18:55):

It is. I'll give you a really little brief example of someone who found that very effective. So this was in a group context, a group of people with borderline personality diagnosis, and so we're listening to the music and this participant's initial response was, I don't like this music, but she couldn't write that down. So she was reflecting on, why don't I like this? It's a love song. Okay, I'm not in a relationship right now. I would like to be. And it's just reminded me of that.

(19:22):

Now that's pretty simple really, but it's not, it's quite deep. And when she said that what she recognised was she wouldn't have actually taken that next step in the analysis if she was allowed to just say, I don't like it, that's bad music. And she reflected on her sister would play songs and she tells her sister that she

hates that song, but she just had this little moment of like, oh wow, it's not actually a bad song, it's just because of what's going on for me in my life right now.

Professor Mark Creamer (19:51):

It's very interesting, isn't it? Yeah. I'm not at the school of thought that says that insight is everything, but a bit of insight is actually quite important in terms of moving forward

Dr Jason Kenner (19:59):

It is, but it's also practising that process. It's saying, hang on, have I put up a roadblock here to actually learn a little bit more about myself? So that insight itself may not have a long lasting benefit, but learning that skill does.

Professor Mark Creamer (20:12):

You gave us a cracking answer to a very difficult question there, but do you want to add anything to that, Jen, in terms of mechanisms or explanatory models, how you think it might be working?

Dr Jennifer Bibb (20:22):

I don't think so. I think the only other thing to add is that although we don't have explanation for why things might be working, sometimes we do have research that shows that it does work. And I think that that shows that the profession is younger. And so I think over time what we'll find is that we start to, as we do more research, we'll start to really understand what's happening and why it's so effective.

Professor Mark Creamer (20:47):

Yeah, I'm sure it's true. And as we alluded, music therapy is not alone in that there's a whole areas of psychological treatment and even physical pharmacological treatments, we don't really understand why they're working if indeed they are.

Dr Jason Kenner (20:59):

There is something more I'd add to it though, and there is some research and theories on this about the level of arousal that you're having during an experience and then how much that can influence the change process. And because music making, we know that it engages so much of the brain, the motor neurons, memories, emotions, a lot, visual processing, everything. And if the person who's participating in the music therapy experience is feeling very engaged, what's been termed by Daniel Stern talking about children, that vitality affect, that sort of sense of vitality, that these experiences are probably more likely to lead to change than just the mundane repetitive processes.

Professor Mark Creamer (21:45):

Absolutely, absolutely. You're preaching to the converted here for me because this is fundamental to working with trauma survivors. I think that you really do have to access that whole memory network, which includes the reactions, the emotional responses, and so on. And includes the interpretations about I'm not safe, everything's danger everywhere. Like your example with the girl with the borderline personality disorder.

(22:07):

Fascinating. Okay, let's move on. And I'm assuming, Jen, that often music therapists would not be working in isolation, but would be working as part of a multidisciplinary team. That'd be right.

Dr Jennifer Bibb (22:19):

Yeah, absolutely.

Professor Mark Creamer (22:20):

And so I'm wondering about whether you can talk a bit about what that collaboration might look like if you're working with a psychologist, for example, or a gp, and how might that play out?

Dr Jennifer Bibb (22:31):

Yeah, so I suppose again, it depends on the setting that you're working in, but just like every other kind of allied health profession, the team works together towards common goals for the person that we're working with. And we all use our own kind of skills and expertise to be able to do that. So say for example, if we're working in a hospital setting, I would use my skills as a music therapist to try and work towards the goal for that person that the whole treatment team is working towards. So that's why it's so great that we are skilled and we understand about health conditions, why we're working towards all the same things as other allied health and mental health professionals as well is because we can adapt to that and work together towards goals using our own skills and methods that we have.

Professor Mark Creamer (23:23):

Absolutely. I mean, one of the criticisms of the field very broadly I think is that we are not great often at talking to the other professionals involved in the person's care. And sometimes that's a funding issue. That case conference is not well funded, but it is so important, isn't it, to be talking to each other really.

Dr Jason Kenner (23:39):

Definitely. And even in terms of understanding the participant, when I worked in one of the public hospitals here in Melbourne and we had our allied health office, and we'd just informally, we'd talk about particular patients and you get so much by just having that multidisciplinary conversation quite what do you think's going on and what have you been seeing? And then we sort of learn a little bit more and to think about how to work with them.

Professor Mark Creamer (24:02):

Different perspectives and so on.

Dr Jason Kenner (24:03):

Yeah, it's fantastic.

Professor Mark Creamer (24:05):

For the benefit of our listener, how might someone refer to a music therapist?

Dr Jason Kenner (24:09):

So there's a lot of NDIS work going on right now, which is including music therapy. And so usually support coordinators or parents of the particular person is interested in music therapy, and so they

usually just Google and then they find someone. So you can go down that path. Of course the Australian Music Therapy Association has a webpage and that's got an address book kind of thing, and it's called Find a Registered Music Therapist. You click on that and you can enter a postcode, put in a kilometre radius, and then you'll get practitioners that are in that area. So it can be done that way. Unfortunately, at present, we're not part of the MBS. So in the same way that someone can currently go to a GP and they can get a referral for psychology, you're not able to get that for music therapy. That's something that we are hoping to change because there are a lot of people that feel that that is the right modality for them, or it might be time for them to give that a try because they've tried different sorts of therapies and they're really interested in something that's a little bit different, a little bit more creative. So the referral process really at present is to go straight to the music therapy practitioner.

Professor Mark Creamer (25:21):

Or as you say, to look on the Australian Music Therapy Association site. And that would give some guidance.

Dr Jennifer Bibb (25:27):

It's important to do that, I think because everyone who's listed on there is registered so that you know they're abiding to a code of ethics and things. If you just do a random Google search, there can be people out there who are not registered.

Professor Mark Creamer (25:39):

So what does it mean? It means, as you say, that they're bound by the code of ethics of the profession, presumably also they have some recognised training and or experience and so on. So this person knows what they're doing if they're registered.

Dr Jason Kenner (25:52):

That's right. And also you can always ask somebody if they are, but it's important, say going back to the NDIS example, you can't use a music therapist unless they are a registered music therapist. So it is important to make sure that the person that you are wanting to bring in as the practitioner is registered so that you can access the funding.

Professor Mark Creamer (26:13):

Good. Jen, tell me in a minute or two that we've got left, what does the future hold for music therapy? Actually, Jason just foreshadowed the idea of getting MBS reimbursements, but generally speaking, the field. Have you got any ideas about where the future might go?

Dr Jennifer Bibb (26:26):

Yeah, so for me, my hope and belief is that it's increased access, as Jason was saying, currently for people who want to have music therapy as part of their treatment plan, they need to have NDIS or be in a school which has a music therapist, or being part of a mental health programme, which has a music therapist already, or you need to pay out of pocket to be able to see a music therapist privately. So for me, it's increased access because we know so much even after the outcomes of the Royal Commission, that it's not the same for everyone. And people deserve the right to be able to choose what's right for them at any point of time. And increasing access to professions like ours, which has an evidence base

and is allied health really means that we're genuinely being client led and recovery based, where people have choices about the treatment, that they receive

Professor Mark Creamer (27:24):

Quite, better access. And the reality is that we've made enormous strides in our understanding, our treatment and mental health, but we've still got a long way to go. And recognising that there isn't one size fits all and actually giving people the opportunity to choose what works best for them is crucial. And part of that, of course is access. Yeah, absolutely. Yeah. Well, we'll keep our fingers crossed for that. We do need to wind up, are there any final comments, any sort of take home messages that you want to make sure are said or that we haven't had a chance to talk about? We've covered a lot of ground over the last three episodes, but anything else?

Dr Jason Kenner (27:57):

I don't have anything to add. It's been a really great discussion. Thank you, Mark. It's been really

Dr Jennifer Bibb (28:01):

The same for me.

Professor Mark Creamer (28:02):

Excellent, excellent. Well, I've enjoyed it as always. Unfortunately, father time has conspired against us and our allocated minutes have run out. So we have to wind up not just for this episode, but also for our little miniseries on music therapy. That doesn't mean that we won't return to the topic, so it may well be that we'll come back and perhaps invite you both back in again for another episode. I have to say that I'm surprised and even a little bit embarrassed about how little I knew about music therapy. So you've certainly taught me a lot and I've no doubt that you've also taught the listeners a lot, and I hope they've enjoyed these episodes as much as we have. So thanks very much indeed for your time today and for the previous two episodes, Jen and Jason.

Dr Jason Kenner (28:40):

Thank you, Mark.

Dr Jennifer Bibb (28:40):

Thank you.

Professor Mark Creamer (28:41):

So as I say that marks the end of our three-part series on music therapy, at least for the time being. But MHPN series a conversation about mental health and the arts will continue with new episodes coming up in future months. So do please keep an eye on their website for more podcasts in this broad area. If you want to learn more about Jason, Jen or me, or if you want to access any resources, please go to the landing page of the episode. You'll also find a link to the Australian Music Therapy Association there. And we talked about that, of course, in terms of finding a music therapist. And you'll find a link to the feedback survey. And please, if you can spare the time, do fill in the survey. It's really important for us to know what you thought about this series, but also to give MHPN ideas about how better they can meet your needs. But for now, thank you very much indeed. Again to you Jason, and bye from you.

Dr Jason Kenner (29:34):

Bye. Thank you Mark.

Professor Mark Creamer (29:35):

And very much thank you to you also Jen,

Dr Jennifer Bibb (29:37):

Bye from me.

Professor Mark Creamer (29:39):

And it's also goodbye from me. Don't forget to keep an eye on the MHPN website for news of future podcasts. But in the meantime, thanks to you all for joining us today and listening to the podcast. Bye for now. Bye.

Host (29:52):

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