

4-24-2015

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Opus Citation

Nancy A. Jackson (2015). Music Therapy and Chronic Mental Illness: Overcoming the Silent Symptoms. *Music Therapy Perspectives*. Oxford Journals on behalf of American Music Therapy Association.
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Music Therapy and Chronic Mental Illness: Overcoming the Silent Symptoms

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ABSTRACT: Finding a comfortable and functional life is a challenge for many individuals living with chronic mental illness. Even when active symptoms are resolved and the individual is deemed “stable,” the residual traumas of mental illness, including loneliness, loss, grief, and stigma, persist, severely reducing quality of life and acting as destabilizers. Our current healthcare system is not inclined to spend time and dollars on symptomatology that is not immediately injurious to self or others or actively troublesome in social contexts, so these lingering symptoms that are psychological and emotional in nature become invisible, except by those for whom they are daily experiences. Research literature from positive psychology suggests that addressing the issues of self-concept, self-efficacy, and quality of life is integral to successful recovery from mental illness. Music therapy provides opportunities for individuals living with chronic mental illness to address these types of subjective goals through music engagement that allows them to be heard, to build relationships, and to re-experience the wholeness of their own humanity. Several music therapy perspectives that incorporate aspects of Positive Psychology Interventions (PPI) are identified, and clinical vignettes are shared that explore just a few of the ways that music allows these individuals to find relief from invisible symptoms, including building new, meaningful relationships, finding new identity beyond mental illness, and discovering enjoyment, camaraderie, and new roles in shared social experiences. The effective incorporation of PPI into clinical practice regardless of theoretical orientation or clinical approach is discussed, as demonstrated by the vignettes.

The National Institutes of Mental Health (National Institutes of Mental Health, n.d.) reports that about 4.1% of the adult U.S. population, or approximately 9.6 million adults, suffer from serious mental illness, at an estimated yearly cost of over \$300 billion per year. These statistics are admittedly conservative, however, since sources for collecting data often do not include population groups likely to suffer from mental illness, such as the homeless or the incarcerated. The National Alliance on Mental Illness (NAMI) (NAMI, 2013) estimates that about 13.6 million Americans live with serious mental illness, and that about two-thirds of these people experience co-occurring mental health and substance abuse disorders. Considering these kinds of numbers and costs, it is not surprising that our healthcare system focuses its attention on the stabilization of active symptoms that are troublesome and/or injurious and cause difficulty in the community. Those who

work with the seriously mentally ill, however, know that stabilization of primary symptoms is really only the beginning of being able to function well in daily life, and that return to the community as functioning and productive members requires far more treatment and support than the simple abatement of the symptoms that cause them to be problematic or harmful to self and others.

Non-pharmaceutical treatment philosophies for individuals with chronic mental illness (CMI) tend to center on behavioral and/or cognitive behavioral approaches in both in-patient and community placements, presumably because these approaches are considered “best practice” (Glancy & Saini, 2005). These approaches tend to be those which are most easily studied and objectively documented. Lack of rigorous testing of other treatment approaches, however, may suggest that these behaviorally based approaches can really only be considered the “most studied,” as opposed to “best practice.” Behavioral and cognitive-behavioral approaches to treatment can be quite effective for helping individuals with CMI learn to control some of their symptomatic behavior and develop more functional social skills, but may do little to identify and address the non-behavioral issues that tend to disrupt long-term stability.

The impact of serious mental illness can touch every domain of an individual’s life. It is not usual for relationships with family, friends, and other social support to be severely disrupted, and even severed completely, because of an individual’s behavior during active episodes of symptoms like psychosis, mania, paranoia, and so forth. Dreams for the future can be erased, and the individual’s identity as it was understood previous to mental illness can be destroyed. In some cases, individuals with CMI find themselves to be entwined in the legal system for criminal behavior committed while in a state of diminished mental capacity. Awareness of these losses as the individual regains some stability can be devastating and should be considered a major *trauma*. Individuals with CMI, who can have significant difficulty reintegrating as functional members of the community, may be repeatedly reminded of this trauma each time they encounter difficulties with illness management, interpersonal relationships, independent living, employment, and coping with the stressors of everyday life. They potentially deal with re-traumatization on a regular, and perhaps even daily, basis.

Onset of numerous CMIs occurs in early adulthood, the time of life when individual identity is taking shape and the ability to exercise independence and pursue hopes and dreams is within reach. Serious mental illness can halt this development, and often shatters the possibility of return to the type of life imagined prior to illness onset. Individuals with CMI often experience a good deal of *grief* in relation to these losses. At the same time, symptomatology that is unresolved (e.g., negative symptoms) and the immobilization of emotions

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doi:10.1093/mtp/miv017

Advance Access publication April 24, 2015

Music Therapy Perspectives, 33(2), 2015, 90–96

that sometimes occurs with pharmaceutical treatment make it difficult to actively work through and resolve feelings of grief.

Building relationships can be problematic for the individual with CMI. Negative symptoms, like blunted affect and the inability to experience pleasure, can make it difficult to interact with others in ways that typically allow people to find connections with others that become the basis for relationships. Interactions with the individual during active episodes of their illness can result in feelings of fear and mistrust from family members and friends that can cause insurmountable obstacles for the individual with CMI trying to rebuild those relationships. These difficulties often result in *loneliness* which, like grief, may be difficult to address and resolve because of the chronicity of the illness itself.

Stigma of having been diagnosed as mentally ill can additionally contribute to re-traumatization, grief, and loneliness. Both misconceptions about, and the realities of, mental illness can lead communities to be suspect about welcoming those with CMI, and in extreme cases, to shun them altogether. This creates somewhat of a “catch-22,” since mental illness does, indeed, cause some individuals to act in ways that are illegal, untrustworthy, scary, and dangerous when they are experiencing active episodes of their illness. Yet, welcoming someone into a social circle like a community requires a level of trust. One can understand the mistrust of those who have witnessed or been hurt by the results of active mental illness, even while empathy and compassion are felt for the individual living with a CMI. From the perspective of the individual with CMI, the stigma may feel like being told “no” before even having asked a question.

The emphasis on objective and measurable goals and outcomes in mental health treatment can leave issues such as feelings of being stigmatized, grief over losses, and loneliness unaddressed. Symptoms like these, which are not as obvious as symptoms that raise concern for immediate safety, can be unrecognized by those in the community who are unfamiliar with mental illness. In fact, the Centers for Disease Control and Prevention (CDC, 2010) found in a national survey that a majority of the non-mentally ill population felt that people in general are sympathetic and caring toward those with mental illness, while a vast majority of those with mental illness felt as if the non-ill population is *not* sympathetic or caring. Those with CMI often lack accurate awareness of self and others because of illness symptomatology, and this may explain such perceptions. At the same time, it would be unfair to assume that these perceptions have no basis in reality. It might be that some members of the general public don't have the knowledge to recognize what constitutes problematic issues for those with CMI trying to make their way within the community. An example of this might be the outcry that is sometimes heard from communities when there are plans to purchase or build homes in which to reintegrate the mentally ill into that community.

At the same time, these silent issues that can be invisible to the non-ill can be ameliorated only through human relationships and social support. If standard treatment focuses primarily on behavioral aspects of illness, while our communities lack some level of awareness and understanding of mental illness and the needs of those who suffer from them, then how do these individuals achieve stability that will allow

them to function as members of a community and provide them with an acceptable quality of life? Without recognition by healthcare professionals that these types of persistent difficulties must be treated or else significantly diminish quality of life and act as destabilizers, those with chronic mental illness will continue to fail in the community and become recidivistic patients in mental health facilities. Treatment approaches that are more holistically oriented, like music therapy, may prove to be especially beneficial for acquiring and maintaining stability and improving the general quality of life.

Aspects of positive psychology can be incorporated into music therapy clinical practice with individuals with CMI in order to effectively address some of these destabilizing problems. Positive psychology shares concepts with a number of music therapy perspectives, and can easily be incorporated into clinical practice regardless of the music therapist's preferred theoretical orientation or choice of music therapy approach. The vignettes below give specific clinical examples of how silent and subjective symptoms like loneliness, loss, grief, and stigma-related problems can be addressed in music therapy, and how the outcomes can include a sense of empowerment, the development of a healthier identity, entering into and maintaining new relationships, and reintegration into the community—outcomes that drastically increase long-term well-being and a higher quality of life for those living with serious and chronic mental illnesses.

Positive Psychology and Chronic Mental Illness

Positive psychology is an approach to addressing mental health concerns that differs from more traditional psychological approaches in that it focuses on identifying and increasing characteristics and strengths that allow individuals to experience their daily lives as being happier and more fulfilling, as opposed to focusing on symptomatology and functional problems (Seligman, 2007). Positive psychology interventions (PPI) encourage and support individual strengths and virtues that lead to a greater sense of well-being and a better quality of life. Wellness aspects identified in positive psychology that are of particular concern for those living with chronic mental illness include those such as identity, hope, optimism, self-acceptance and responsibility, overcoming stigma, resiliency, social support, and meaningful activity. While some of these aspects might be touched upon in in-patient treatment, they are typically not the main concern, nor are they the main focus of consideration during discharge planning and community placement. At the same time, deficits in these areas of wellness are directly related to poor quality of life at best, and to relapse and re-hospitalization at worst.

Many PPIs have been commandeered by the self-help movement, causing some to question the veracity of this type of approach in providing any real help to those with chronic mental illness because of oversimplification (Rashid, 2009), and even to suggest that they “blame” the victim when happiness and contentment cannot be achieved (Azar, 2011). When properly approached, however, PPIs support a process of change over time that imparts the skills necessary for finding satisfaction in everyday life (Rashid, 2009). In a recent meta-analysis of positive psychology research, Bolier et al. (2013) found that PPIs seem to be quite effective in improving a general sense of well-being and decreasing symptoms

of depression. Indeed, self-esteem has been found to increase satisfaction in daily life, while it simultaneously decreases problematic symptoms of mental illness (Markowitz, 2001).

A number of studies that explore the process of recovery from the point of view of those diagnosed with mental illness also provide support for positive psychology and other interventions that are focused on self-concept and quality-of-life issues. Recovery stories from and interviews with individuals diagnosed with mental illness have revealed the importance of social support, personal empowerment and a sense of independence, and a positive outlook on both the present and the future, in combination with more traditional treatment concerns such as appropriate medication and meaningful activity, as vital parts of successful recovery (Smith, 2000; Mancini, Hardiman, & Lawson, 2005). They have described how the development of hope, self-acceptance, self-responsibility, and self-efficacy allowed them to function better in and derive more happiness and contentment from their daily lives (Brown & Kandirikirira, 2007). In addition, building relationships in the community and with peer groups in a similar process of recovery has been directly related to higher self-esteem in individuals with chronic mental illness (Ilic et al., 2012).

Music Therapy and Chronic Mental Illness

Music therapy has traditionally been a treatment modality that naturally incorporates concepts that are in line with PPI. Some of music therapy's earliest theorists wrote about the positive experiences that music provides for people with limitations, the ability of music experiences to compensate for limitations, and the social interactions that are a primary aspect of engagement in music (e.g., Gaston, 1968; Sears, 1968). It is a standard of practice that music therapists identify not only the problems and limitations that their clients demonstrate, but also their strengths and abilities (American Music Therapy Association, 2013). These strengths and abilities can be utilized within the treatment process, and can lead to increased success within therapy sessions, increased self-esteem, and feelings of empowerment—aspects in common with PPI.

The relational quality of music may be one of the most unique and powerful features of music therapy for people who suffer from serious and chronic mental illness. Both stigma (originating from others) and symptomatology (originating from the individual) create a chasm between the individual with mental illness and the communities that would normally provide the interpersonal support that is necessary for health and well-being. That chasm can be bridged in music therapy, as engagement in music creates a safe and affirming experiential container in which limitations and misunderstanding can be left behind, and new awareness and understanding can develop. Kenny (2006) wrote about this experiential space, calling it the "field of play," a space in which musical interaction opens up numerous potentials that allow the participants to be revealed in the wholeness of their humanity. For the individual with CMI, this type of engagement allows an experience of freedom from the fetters of stigma and limitation, and a re-acquaintance with one's own human identity. It also provides the opportunity to make connections with other human beings in ways that symptoms of illness may prevent in usual daily interactions.

In this sense, music is not a "tool" to be "used" to help people with mental illness, but instead is an interactional experience of being human. As Garred (2006) points out, when

music is used in an objectified manner, it leads to human beings also being conceptualized in an objectified manner. Those with CMI are already objectified in the sense that others without illness tend to understand them in terms of their symptomatology and not in terms of a human being who has both typical and specialized needs. Engagement in music invites the individual with CMI back into a shared human experience that provides for basic human needs—belonging, safety, relationship—as well as creating a space in which strengths can be mobilized and utilized in order to more functionally address the issues and limitations of chronic illness. Again, these are all aspects of the therapeutic process that music therapy in general shares with PPI.

A fascinating thing about music therapy is its ability to be understood and practiced from many orientations and using numerous approaches. When working with individuals with CMI, the music therapist can incorporate concepts of PPI even when practicing from various perspectives and utilizing different methods of music engagement. Several perspectives on music therapy practice have basic concepts that they hold in common with positive psychology. For example, dialogical music therapy, which primarily involves music as therapy, focuses on the outcomes of musical communication as a means of building relationship, developing understanding self and other, and developing resources that lead to empowerment (Garred, 2006). Resource-oriented music therapy focuses on the identification and development of strengths, resources, and potentials that can increase functionality and personal empowerment (Rolvjord, 2010). In this perspective on music therapy, the therapeutic process is collaborative, and recognizes the client as an individual as well as part of a larger community context. In community music therapy—which is neither an approach nor a specific orientation, but is a way to conceptualize music therapy in terms of the relationships between the individual and the social contexts and communities in which the individual is embedded (Aigen, 2012)—engagement in music between individuals within a social/community context provides opportunities for the reciprocal promotion of health and well-being. It is characterized by qualities such as active participation, inclusiveness, and shared leadership (Ansdell, 2002). Within all of these perspectives is the intention to strengthen the client, not just as an individual, but as a member of a larger context in which they have identity, meaningful roles, and equity as a vital constituent.

Some of these concepts are illustrated in the following vignettes. It is important to note that in none of these instances was a specific approach to music therapy being employed. Instead, the therapist addressed the needs of the client(s) as they were expressed in that moment, which included some of the silent symptoms of individuals with CMI, such as difficulty developing relationships, loss of identity, grief over losses, and the stigma of mental illness within the community. These vignettes are examples of how music therapy can incorporate concepts of PPI even if the clinical practice is not couched in an approach that formally encompasses PPI.

Vignette 1—Building Relationship through Music Engagement

Chuck was a 30-year-old man diagnosed with schizophrenia and additionally suffering from a recently occurring

affective component to his illness.¹ He tended to be uncompliant with recommended pharmaceutical treatment because of the distasteful side effects, and therefore was poorly stabilized even on the occasions when he did take medication. He was a musically gifted young man who had begun playing guitar at an early age in hopes that he could build a relationship with an older sibling who played in a local rock band. His illness interfered both with his effective development of his musical skills and with his ability to build and maintain relationships with others, including his brother. Music therapy was a haven for Chuck, and it was one of the few treatments in which he actively and wholeheartedly participated.

Jeff was a 20-year-old man just diagnosed with schizophrenia after a significant psychotic episode. He was in college studying engineering when he began experiencing symptoms of his illness, and the first episode occurred quickly and with destructive results. He had always been a loner, and had spent hours by himself watching movies and listening to music. He was struggling with acceptance that he had a mental illness that was likely to be a lifelong issue when he began attending music therapy.

In music therapy, Chuck and Jeff initially interacted very little with each other, both interacting with the music therapist in a functional but superficial manner. Attempts by the music therapist to get the two men to engage directly with each other had not been very successful. While they had played various instruments together during sessions, both tended to simply imitate the therapist's manner of playing, and neither played creatively or showed an interest in the other and his playing. One day they entered the music therapy room, which had two full-keyboard xylophones set up facing each other. Chuck went straight to one xylophone, picked up the mallets, and started playing somewhat chaotically. Jeff immediately followed him over and began playing the other xylophone. The music therapist silently watched as Chuck and Jeff began looking at each other, copying or responding to what each other was playing, and eventually moving into a full, interactive improvisation with each other. The improvisation continued for more than 25 minutes, during which the music therapist witnessed that Chuck and Jeff were truly communicating with each other. Their involvement in the music process removed them from the power of their illnesses in that moment, and revealed the whole person within each. Even more importantly, it allowed each to recognize and connect with the whole person across from him. Their music became a "playground" in which the musical elements revealed curiosity, humor, sharing, empathy, and the development of trusting relationships. As the improvisation came to its natural conclusion, the young men were silent. They looked at each other momentarily, and then Chuck turned and walked out of the room, grunting a "Bye!" to the music therapist. Jeff followed directly behind, giving the music therapist a little smile and simple wave as he exited the room.

In the weeks that followed, Chuck and Jeff were inseparable. The staff marveled at the change in each of them. They were frequently found sitting silently outside the front door of the hospital smoking, sometimes sharing the only cigarette

that either of them had. When they came to music therapy, they not only interacted, but challenged each other in caring and supportive ways. Jeff would say to Chuck, "No one is against you. You're crazy, man!! You *have* to take your medicine." Chuck would say to Jeff, "You aren't someone different than you were before just because you got sick!" Each would accept this type of feedback from the other when neither could hear similar messages from anyone else. When discharge time approached, each talked with his social worker about finding supportive housing in the same community as the other, stating that this friendship was a primary support. For Chuck, it was the only social support he had been able to maintain in many years. Their connection in music allowed the development of a healthy and caring relationship that is seldom seen between people who experience the severity of illness that these two young men experienced.

Both clients in this example were at high risk for loneliness upon return to the community, due to the impact of their CMI on their ability to create relationships. In addition, the newly diagnosed client would be dealing with the initial grief over the losses in his life caused by his diagnosis and the resulting stigma. Musical communication between the two clients opened up the potential for healthy interpersonal connections. This type of meeting within a musical dialogue that leads to relational change was discussed at length by Garred (2006) in his discussion of the dialogic in music therapy, and represents a subjective and difficult-to-measure change that may potentially be life altering for the participants. In the case of Chuck and Jeff, it was a moment of being heard and understood in a way that allowed a normal, healthy, and caring relationship to develop, and it had a lasting, positive impact on their daily lives. Others have reported similar results working with those with CMI in music therapy, including Pavlicevic, Trevarthen, and Duncan (1994), and Grocke, Bloch, and Castle (2009).

The music engagement in this situation was initiated and carried through to completion by the clients. The music engagement itself was the agent of change, not some type of higher-level verbal processing that led to insight. The music therapist had brought the young men together, and had created conditions within the music therapy sessions in which they were encouraged to explore and interact. Her role in this session, though, was simply to provide the opportunities and resources that were needed for engagement to occur.²

Vignette 2—Voicing Identity and Empowerment

Cynthia was a 45-year-old woman who had suffered from misdiagnosed bipolar disorder for many years. When in a manic state, she often had experienced complete psychotic breaks, and when she would plunge into deep depression she had made numerous suicide attempts. A fragile, partial stability had been achieved once she was properly diagnosed, but maintaining it seemed to be like walking a tightrope for

¹ In this and the following vignettes, pseudonyms are used for the clients, and certain aspects of the stories have been altered to protect the confidentiality of the individuals. Individual permission was given by all clients for the use of case materials for education and publication purposes.

² Bruscia (1998) defines therapy-induced change as that which requires a therapeutically focused intervention facilitated by a qualified individual within a therapist-client relationship. While the example here might appear to diverge from this definition, the music therapist was a primary part of the equation in a more general way. The clients came to music therapy because of an established therapeutic relationship with the therapist, and the therapist intentionally created the space in a manner that was conducive to the clients' active participation in the music therapy process. In the context of the field of play (Kenny, 2006), this meeting in music engagement was made possible by the conditions that were created by the therapist, both in previous sessions and within the space during this session.

Cynthia. The losses of her marriage, children, family members, and friends, as well as her socioeconomic status through her years of illness, acted as a constant threat to her tenuous stability.

Cynthia was quite despondent and hopeless about her future. She had had little success each time that she had been discharged into the community, even though she was discharged to housing placements that provided supportive assistance. In particular, Cynthia expressed feelings of having been “victimized” by her mental illness, as though it were some type of external enemy who interfered with her ability to act on her own behalf and make any progress. During her assessment for music therapy, it was notable that Cynthia played the xylophone moving only her right arm. Her left arm remained static as she struck only one note with that mallet. With the right mallet, she played within a range of three pitches. Her lack of musical expressiveness was reflective of her general sense of “doom and gloom.”

The music therapist engaged Cynthia in a series of improvisations over the next few weeks, encouraging her to use different instruments and her voice to express exactly how she felt and what she was thinking. In these improvisations, Cynthia played and sang about her many losses, especially about the loss of the identity that she had expected to have as an adult and as she grew older. The music therapist supported her playing and singing both musically and verbally, encouraging Cynthia to express anything and everything that she was thinking and feeling about herself and her illness. And indeed, years of anger, frustration, fear, and shame poured out in her music throughout the sessions. Sometimes she and the music therapist would verbally process her improvisations, and other times they would sit in silence, letting the power of what Cynthia had expressed be witnessed.

One day as she was improvising by herself using a guitar, Cynthia spontaneously began singing about her identity. She sang about how her illness had defined who she was for so many years and how that identity was so different from what she had hoped for and expected. She sang about the way that others rejected her on a daily basis. As she sang, her strumming became very forceful and rhythmic, and she sang:

“You thought you made me a victim
I believed you—that I am a victim
But you are just an illness
I was [Cynthia] before I was an illness
I am [Cynthia] still!
I am not an illness, not a victim,
I am a victor!
I will be victorious over illness!”

After singing these words, Cynthia suddenly stopped and looked at the music therapist with a look of complete surprise on her face. It had never dawned on her that she could envision herself in any way other than as a mentally ill person. The music therapist suggested that Cynthia create an anthem that expressed what being victorious felt and sounded like. Cynthia asked the music therapist to play along on a large Tubano as she played on a xylophone. As she played, Cynthia smiled and laughed authentically as she used both hands to play a dynamic and expressive improvisation that spanned the full length of the xylophone. Afterward, Cynthia and the music therapist talked about identifying new hopes for her

future, and in the coming sessions, they engaged in songwriting about those hopes and about how she could realistically create a functional and comfortable life for herself despite her illness.

Cynthia’s story depicts the trauma and grief often experienced by those with CMI, as well as the loss of healthy identity. Her work in music therapy demonstrates aspects of a music therapeutic process similar to resource-oriented music therapy that addresses subjective and difficult-to-measure change. Cynthia had met treatment expectations about what she said and how she behaved on numerous previous occasions as she was discharged from the hospital setting, but what she said and did was a façade covering her internal experience. But this time was different because of what she actually believed about what she was saying and how her behaviors came from an empowered place instead of from external shaping. The music experience in which she was engaged with the music therapist provided a safe space to feel what she actually felt, express what she needed to express, and be heard and accepted by another human being, as well as seeing herself reflected in that other. She was able to recognize that she had strengths and resources that remained despite her illness. In response, Cynthia was able to work through some of the grief over her many losses and to develop a more complete and realistic self-identity that supported a more successful transition back to the community. Solli, Rolvsjord, and Borg (2013) recently explored the usefulness of music therapy for mental health recovery through a meta-synthesis of the literature, and specifically recommended that approaches in music therapy that strengthen personal resources and empowerment be utilized to assist clients in successful recovery, reflecting similar findings in the positive psychology literature (e.g., Brown & Kandirikira, 2007; Mancini, Hardiman, & Lawson, 2005; and Smith, 2000).

The clients in the preceding vignettes were receiving treatment in a hospital setting, a place in which one would hope that all aspects of their illnesses would be addressed. It is in this setting that the seeds can be sown that can grow into increased resilience in the community. Music therapy in outpatient and community settings can answer the instances in which such seeds were not sown in more controlled settings, and can further support the continued development of resilience and functionality of those with CMI in the community even as the care and support of the general population toward individuals with CMI may not quickly change.

Vignette 3—Finding a Place through Performance

In a community mental health clubhouse (a non-treatment-related agency providing daytime support for people with CMI), the music therapist secured a grant to purchase instruments for club participants. Some of the club participants were formal clients of the music therapist, and others chose of their own volition to participate in the group the music therapist offered. The group loved to sing their favorite songs together, and with the addition of the new drums and small percussion instruments that the music therapist purchased, they could also play along as they sang.

As they played and sang together, the group found that they particularly enjoyed several songs that were used at a religious service that a couple of group members attended each week.

They wondered if they might be able to prepare these songs in a more formal manner and perform them together during a service. The music therapist agreed to go with the two clubhouse participants and speak with the minister at the church they attended. The minister was receptive to the idea and suggested that the group perform at a weekday social event that was scheduled for a future date.

The group organized its use of music time to work on the two songs they chose to perform at the church event. They worked together to agree on how to accompany their singing with percussion, and the therapist worked separately with the group member who knew how to play guitar in order to strengthen his skills. They also decided that one group member who had a particularly nice voice should have a solo in the middle of one of the songs. By the date of the event, they had prepared a well-polished performance that was received with great enthusiasm by the church community attending the event. Afterward, the minister asked if the group would like to sing during Sunday services.

The group was thrilled to have performed so well and to have been so well received. Some voiced feelings of surprise that they could actually do a performance that others would think was good, and the woman who sang the solo part told the others that she had been “so afraid” to sing by herself but now felt very proud for having been able to overcome that fear. They congratulated one another and proudly shared with other clubhouse participants and staff what they had accomplished. They decided together that they would accept the offer to sing during Sunday services, but realized in consultation with the music therapist that it was unrealistic to think that they could be prepared to do it every week. They discussed this with the minister and agreed to perform once a month at a Sunday service.

In the months that followed, the group began to take responsibility for picking appropriate songs to prepare for their church service performances, and making choices about what instruments and vocal arrangements were most appropriate considering the style of the song and the abilities of the group. The music therapist continued to help them prepare and access various resources that they needed for preparation.

Meanwhile, the church congregation began to develop relationships with the group. The group members were invited to participate in other functions and events at the church, and some group members developed social relationships with individuals in the congregation. In effect, the group was embraced as part of the church congregation, allowing them to experience a sense of support in a community that was not focused on mental illness. They experienced providing something of value to that community, and they experienced the development of functional relationships with others. In return, the church community came to know the group as individual human beings with unique personalities and strengths, not as a group of people with chronic mental illness.

The inability to find a place to belong in the community is an enduring problem for individuals with CMI, leading to loneliness and difficulty in developing a healthy identity. Bridging the gap between community and those with CMI is an integral part of successful reintegration into less restrictive environments. In this instance, the group’s therapeutic engagement in music reflected aspects of community music therapy.

The music therapist assisted the group’s music engagement within the context of their own community. The focus of the therapeutic intervention was not for each participant to meet specified objectives, but instead was to assist the group in reintegrating into the community in a way that would provide support and encouragement for healthy daily functioning. Building relationships through group music-making and performance helped bridge the chasm between the ill and the non-ill, allowing human-being-to-human-being interactions. Also similar to resource-oriented music therapy, the group members were able to experience that they had something of value to offer to others, and that they could take responsibility for making choices about how to go about sharing. These are healthy behaviors for members of a community, and not behaviors that the general population might assume individuals with CMI possess. Yet, with appropriate guidance and support, these individuals demonstrated that they were not their illnesses—they were human beings, each with their own constellation of strengths and limitations, as we all are. An example of a similar and highly successful program is reported in the music therapy literature by [Baines and Danko \(2010\)](#).

Synthesis/Conclusion

Each of these vignettes demonstrates the effectiveness of music therapy in addressing one or more of the silent symptoms of CMI. The approach of the music therapist was different in each, and in each case, it is easy to speculate on the more concrete goals and objectives being addressed by the therapist; yet, at the same time, the subjective issues of relationship, identity, self-esteem, empowerment, and overcoming stigma are an integral part of the outcomes of treatment. Integrating aspects of PPI for clients with CMI can, therefore, be reasonably incorporated into treatment implementation regardless of the music therapist’s theoretical orientation or approach if the therapist makes use of the inherent flexibility of music and integrates concepts from music therapy perspectives, such as dialogic, resource-oriented, and community music therapy, into clinical decision-making.

It is sensible and realistic to be concerned with decreasing the societal costs associated with chronic mental illness. In order to do this, however, it makes little sense to continue treating only overt, behavioral symptoms once pharmaceutical stability has been achieved. There needs to be a greater recognition that mental illness creates trauma that individuals silently experience every day, and which undermines their ability to access their own strengths for resilience and recovery in the community. Music therapists are in a unique position to bring attention to these issues in both in-patient and community care settings. Certainly music therapists can continue to support the behavioral changes that are the typical treatment goals and objectives, but they can also educate treatment and case management teams about how addressing trauma that results in grief over losses and separation from human relationships can further support those goals and objectives and can ultimately lead to greatly improved recovery and successful reintegration into the community.

Concepts of community music therapy need to be seriously considered by music therapists who work with those with CMI. This perspective has much to offer in terms of building the social relationships and support that will help

heal the grief and loneliness of the ill, and will help in rebuilding an identity that encompasses more than mental illness. Incorporating aspects of the dialogical music therapy perspective can assist those with CMI in developing better self-awareness and understanding of self in relation to others and to their own social contexts. Likewise, the resource-oriented music therapy approach has much to offer for assisting those with CMI in discovering their personal strengths and skills that will allow them to feel empowered to make positive changes in their lives and equip them with skills to carry out those changes. All of these perspectives focus on the health and well-being of the individual as a constituent of the greater community, an aspect of recovery and well-being that is often lacking in our current healthcare climate. Music therapists can look to the positive psychology research literature to supplement the music therapy literature for making the case that focusing on these objectives around self-concept and quality of life is not just a sensible approach to providing care for the individual with CMI, but should be considered part of “best practice.”

In a recent music therapy blog post, this statement was made: “For far too long we have tried to fit music therapy into a pre-existing description of professions that address similar treatment needs. What we need to do is provide a clear, distinct, and very specific narrative of music therapy so that all stakeholders and decision-makers ‘get it’” (Simpson, 2014). Indeed, music therapists have the opportunity to speak up on behalf of people with CMI, illustrate the ways in which addressing the silent and invisible symptoms of mental illness are a necessity for stability and recovery, and demonstrate that doing so is not just the appropriate, ethical, and humane thing for our clients who suffer from chronic mental illness, but is also in the best interest of our greater society.

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