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Editorial

Music therapy for depression: it seems to work, but how?†

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Summary
Evidence is beginning to emerge that music therapy can improve the mental health of people with depression. We examine possible mechanisms of action of this complex intervention and suggest that music therapy partly is effective because active music-making within the therapeutic frame offers the patient opportunities for new aesthetic, physical and relational experiences.

Declaration of interest
A.M. and M.J.C. are members of the International Centre for Research in Arts Therapies (ICRA), a non-profit group that aims to promote research in the arts therapies.

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According to a national poll of listeners to a popular BBC music station in 2004, the best way to ameliorate one's depressive symptoms musically is to listen to 'I Know It's Over' by The Smiths.[1] Alas, the widespread availability of down-hearted rock does not appear to have diminished the prevalence of depression. And although listening alone to music that is personally meaningful is what many people imagine music therapy to be, the reality as practised in the UK and in many other parts of Europe is quite different.

It is therefore gratifying to read the article by Erkkilä *et al*[2] in this issue of the *Journal* that reports the results of a randomised controlled trial of interactive one-to-one music therapy for adults of working age with depression. In this study, conducted in Finland, trained music therapists engaged participants in up to 20 sessions of co-improvisational active music-making as the basis of a therapeutic relationship. This is a high-quality randomised trial of music therapy specifically for depression and the results suggest that it can improve the mood and global functioning of people with this disorder.

Among the challenges involved in evaluating complex interventions such as music therapy are those associated with treatment fidelity. Erkkilä *et al* have addressed this issue by ensuring that the music therapists who delivered treatment all completed an extensive induction focused on ensuring fidelity, and videotaped their sessions with participants to monitor adherence. The attention to fidelity is borne out in results that do not vary between therapists. This suggests that the agent of change is not likely to be the personality of the therapist or the nature of the particular therapist–patient alliance (as highlighted by the common factors approach, for example Messer & Wampold[3]) but rather may be attributable to the music or the therapy (if they are indeed distinguishable).

So why might this be so? Aside from any explanations derived from non-musical aspects of the therapy, the authors report that 'active doing' (i.e. the playing of musical instruments with the music therapists) was important to many participants in the active arm of the trial. They suggest that this is an important characteristic of music therapy and a meaningful way of dealing with issues associated with depression. We would like to suggest that this 'active doing' within music therapy has at least three interlinked dimensions: aesthetic, physical and relational.

Meaningfulness and pleasure

First, the relationship between a diagnosis of depression and an experienced lack of pleasure and meaningfulness in life is well established. Perhaps in response to this, there is also a well-established recognition of the value of meaning-making via aesthetic experience within psychotherapy (e.g. Zukowski,[4] Hagman & Press[5]). Here the conception is of the whole (verbal) therapeutic process as essentially aesthetic: how much more of an immediate aesthetic experience is on offer where the therapeutic interaction is musical? In music therapy, the therapist brings their musicianship to the musical encounter by listening acutely and attuning to the musical components implied in the patient's improvised sounds. For example, the therapist might draw out a shaky pulse or reinforce an implied tonal centre. Or they might create suspense or an implied direction (using a bass line or a harmonic progression underpinning an individual's melodic fragment) to entice a withdrawn person to engage in the relationship. There are often moments in music therapy when there is a 'buzz' between the two players, for example when they spontaneously come together at a cadence point or somehow know when to end or where to go next.

When a satisfying aesthetic is achieved within a co-improvised musical relationship there is potential not just for some kind of catharsis but for development, even if the music is not used as a springboard to discussion and insight: the aesthetic draws in the players to take the risk of doing things differently with others – to behave differently towards each other and to experience themselves differently.[6]

Physicality

Second, and rather obviously, the act of playing musical instruments requires purposeful physical movement. The role of physical activity in averting depression and alleviating its effects is well recognised. This is not simply a matter of getting people

†See pp. 132–139, this issue.

moving, but also of enabling people to experience themselves as physical beings. Music has its own internal sense of meaning founded on structure and cultural norms: this engages us and draws us into it whether or not we are aware of it on a technical level. Hence we find ourselves tapping our foot along to a song on the radio or being dissatisfied by a piece that does not finish as we expect. We are therefore entrained into musical participation: music itself offers us ways in – even in circumstances where we may feel distinctly unmotivated. Where we find ourselves musically entrained into physical participation with others we can have a physical experience of ourselves with others. This mirrors the experiences of musicians when playing in groups as can be seen in the coordinated movements of the players in a string quartet.[7] Our participation in turn enables us to hear (and feel) ourselves in the context of the aesthetic experiences outlined earlier, and this lends a potent sense of being part of something meaningful in the here-and-now:

. . . music heard so deeply
That it is not heard at all, but you are the music
While the music lasts.
(T. S. Eliot: p. 48)[8]

Relating

This leads to a third category of 'active doing': the relational. Our first experiences of relating (with our primary caregiver) are fundamentally musical. Developmental psychologists use musical vocabulary to describe the finely attuned interplay of gesture and sound between parent and newborn baby (e.g. Hobson[9]): it is in this pre-verbal interaction that we first learn who we are, how to think and to take pleasure in the possibilities that the world around us has to offer. Where mothers of infants are depressed, the musicality of infant-directed speech and conversational engagement is demonstrably affected with significant developmental implications for the child.[10] These early experiences of musicality are frequently offered as a rationale for music therapy as a whole (e.g. Trevarthen & Malloch[11]) and from this perspective the role of the therapist can be seen as neo-parental: musically nurturing the patient in order to facilitate a similar process of discovery of self and self in relation to others, including the capacity for experiencing meaning and pleasure. Once again, it is music itself that facilitates this: a melodic riff, a harmonic progression, a rhythmic catch – these all naturally engage people in active participation (and hence meaning-making) in ways that words may simply not be able to. It has been argued that music therapy builds on people's capacity for communicative musicality, that we are hard-wired for this kind of engagement and interaction, and that through music-making we experience a kind of relating that is very different from that which talking has to offer.[12]

Music – therapy?

In these respects, then, music cannot be treated simply as a stimulus intended to provoke a predetermined behavioural response. Rather, music-making offers what DeNora[13] terms affordances – physical, relational and aesthetic. Above all, music-making is social (and hence interpersonal), pleasurable and meaningful: this may also be why randomised trials of music therapy have shown high levels of engagement with patient groups who are traditionally difficult to engage (e.g. Talwar *et al*[14]).

Clinical trials inevitably focus on the outcomes of interventions rather than the process through which these outcomes may be achieved. Further research using mixed methods is needed if a better understanding of the active ingredients of music therapy that enhance patient outcomes is to be reached.

Nevertheless, Erkkilä *et al*[2] lay down a clear marker for the value of music therapy as part of the range of interventions available for the treatment of people with depression.

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