Musical Intervention in Family Therapy

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The family therapy approach to treatment is an outgrowth of individual therapy and can present optimal opportunities for the use of music therapy. Three major schools of thought in family therapy—systemic, structural, and strategic—provide treatment objectives that lend themselves to musical intervention. The structural family therapy school of thought in particular lends itself to music intervention due to its concern with balance of power, limits, boundaries, and family roles, which can be addressed through various musical exercises and techniques. Musical intervention within a family therapy context is a new and relatively unexplored avenue of treatment deserving of further research.

Introduction

Origins of Family Therapy

While individual therapy examines pathology in a setting exclusive of social context, family therapy directly explores the function of pathology within the confines of the family as a social system. Traditional Freudian therapy utilizes the dynamics of a private, one-on-one relationship to elicit the transfer of habitual reactions and attitudes toward principal family figures onto the therapist. In this way, dynamics of the patient's family interactions are indirectly brought into treatment for examination. Family therapy
carries this concept to its logical extension by actually bringing the family (with its dynamics) physically into the treatment setting.

There is a plethora of philosophical schools of family therapy, including: psychoanalytic family therapy, experiential family therapy, behavioral family therapy, group family therapy, structural family therapy, strategic family therapy, extended family systems therapy, contextual family therapy, etc. While research in various clinical areas, such as hospital psychiatry, group therapy, child psychiatry, and the treatment of schizophrenia, was concurrently approaching a model that included family members, it is difficult to ascertain who actually founded the field of family therapy.

Nichols (1984) speculates:

> Although there are rival claims to this honor, the distinction should probably be shared by John Elderkin Bell, Don Jackson, Nathan Ackerman, and Murray Bowen. In addition to these originators of family therapy, Jay Haley, Virginia Satir, Carl Whitaker, Lyman Wynne, Ivan Boszormeni-Nagy, James Framo, Gerald Zuk, Christian Midelfort, and Salvador Minuchin were also significant pioneers of family treatment. (p. 41)

For the purposes of understanding the potential role music therapy may play in family therapy, this article will focus particularly on the basic concepts of systemic, strategic, and structural family therapies and their potential interface with music therapy. This is not to diminish other schools of family therapy, but to begin to build a foundation for integrating music therapy with primary, yet divergent, philosophical schools of family therapy.

Approaches to Family Therapy

**Systemic Family Therapy**

Murray Bowen is commonly acknowledged as a founder of family systems therapy. Bowen began treating family members of schizophrenic patients in 1954 and then initiated large multi-family meetings in 1955 (Nichols, 1984) before refining his ap-
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Two fundamental concepts articulated by Bowen are (a) "self-differentiation," the process of extricating oneself from the family's "undifferentiated ego mass" (Nichols, 1984, p. 51), and (b) the notion of the triangle as the basic stable unit of human relationship. In Bowenian therapy, when emotional dissonance exists between two people, it is often relieved by one of the parties "triangulating," or drawing in a third person. This may be done by such means as complaining to the third party or requesting their involvement in some way.

The techniques Bowen utilized include the therapist focusing on process rather than content (to expose the patterns of communication and group functioning), and the therapist taking "I" positions (to model moves of self-differentiation for family members to emulate) (Nichols, 1984). An "I" statement is a clear expression of one's view or belief in relation to other people.

Strategic Family Therapy

Jay Haley focused on the marital pair while working in Palo Alto, California, in the early sixties. He described symptoms as representing incongruence between levels of communication (Nichols, 1984). The different levels range from communication of content (the simplest level) to attempts to define the relationship (the more complex levels involved with struggles for power). Haley was strongly influenced by the work of Milton Erickson and incorporated Ericksonian techniques into his approach as he developed a highly directive and strategic therapy, a therapy designed to render a positive outcome whether or not the directives of the therapist were complied with.

One example of this paradoxical technique used by Haley (and Erickson) involves prescribing the symptom (Nichols, 1984) in order to establish that either the patient is capable of successfully completing the therapist's assignment or is able to change the offending behavior. This technique is illustrated via Haley's treatment of a photographer who sought therapy because he ruined
every picture with some simple mistake:

Haley instructed him to go out and take three pictures, making one deliberate error in each. While seeming to perpetuate the patient’s problem, Haley was in fact paradoxically directing symptomatic behavior in such a way that the patient gained control of it. (Nichols, 1984, p. 47)

**Structural Family Therapy**

Salvador Minuchin developed a structural style of family treatment while working at the Wiltwyck School for Boys in New York and moved on to become the director of the Philadelphia Child Guidance Clinic in 1967. At the Clinic Minuchin worked with Jay Haley, Braulio Montalvo, and Bernice Rosman to develop an extensive and innovative training system that made use of videotapes and live supervision. Training also included giving suggestions to trainees during actual therapy sessions.

Techniques that Minuchin established include questioning about who does what chores and fills what roles in the family, as a way to determine the structure of the family system; “joining” with the family to help diffuse resistance; and “restructuring,” which is active maneuvering with an aim to alter dysfunctional structures by strengthening loose boundaries and relaxing rigid ones. Structural family therapy is also concerned with where power lies in the family and how it is wielded.

Balance of power within the family may be examined by noting who does what to whom, and who has control. Issues of limits and boundaries will appear within the family therapy session (Minuchin, 1974) and may be addressed at the time they are exhibited. Boundary issues typically occur when parents have previously been negligent or inconsistent in instituting limits and then consequences. The concept of family roles (Minuchin, 1981) can help the therapist and the family understand the behaviors exhibited within the family and may aid in establishing goals to work toward in therapy.
Recent Trends in Family Therapy

Sandra Soll, a trainer for the Philadelphia Child Guidance Clinic, suggests being particularly attuned to the functional, as opposed to the chronological, age levels at which different family members are operating. Each family member has both a chronological age level and a functional age. For example, a mother may have a chronological age of 38, but a functional age of 14; her son's actual age may be 15, but his acting age may be 18. One of the goals of a structural intervention in a case like this would be to elevate the mother to the position of mother (Soll, 1991), since their current interactions appear more as sibling to sibling.

One of the therapist's jobs is to coach the parent (Haley, 1987) in establishing the parental boundary that delineates the parent functionally as the caretaker. The therapist can intervene in a session to direct the family members toward more age-appropriate and role-appropriate behaviors. Family members can try on these new behaviors during the session under the guidance of the therapist.

Common to all of these approaches to family work is the concept of the family as a functioning system comprised of members who each play a role in maintaining the functioning of that system. When a change occurs in one part of the system, it affects the entire system.

Music in Family Therapy

Qualities of Music that Complement Family Therapy

Music possesses unique qualities that make it useful in group or family work. One primary quality of instrumental music is that it is a medium of communication composed of the elements of language (tones and rhythms), yet it does not carry the specific associations of words. One of the advantages of using the musical medium to begin the re-establishment of a balance of power is that the "hot" issues that might automatically trigger habitual strong feelings and attitudes may be temporarily placed on the back burner. For example, if the family typically reverts to hostile arguments around such subjects as taking out the trash, having
privacy in the bathroom, or using drugs, they may be able to progress more quickly in developing healthier communication patterns and more functional family roles when the content of the interaction is neutral.

The choice of musical intervention is especially congruent with structural family therapy, which concentrates on patterns of interaction in the present. Since it is the broken or unbalanced structure within the family that is the key element needing to be addressed, rather than the specific arguments, (Nichols, 1984), observing a family’s music-making style allows the therapist to examine the process of the interaction and family structure without the distractions of the content.

For example, spouses who typically battle each other and use their children for leverage may begin to experience working together via music in relationship with their children. This may be a drastic change in the quality of interaction for the family, and it would be important for the family members to have an opportunity to discuss what the experience of making music together was like for them and how they felt about it—either following the music in the family session or later in individual therapy.

Another useful characteristic of music within a therapy session context is that musical instruments typically evoke interest and curiosity, attitudes that this author often observes to be lacking in family therapy participants. Children especially tend to be attracted to musical instruments and like to explore them by beating the drum, striking the keyboard, and shaking the maracas or afuche (a Brazilian shaker with metal beads and wooden handle). While adults may be more reserved in their approach, they, too, are often drawn toward instruments and may either comment on them or even casually brush or touch them.

Music offers another neutral context with which to assess family members’ relationship—through the element of rhythm. Rhythm is a formidable quality because it demands structure. By observing how the family responds to the demands of rhythm, the therapist can construct a formulation as to how each member responds to structure in general. For example, within the context of a strong musical rhythm, some family members may join “on the beat”; others may come in on the “offbeat”; still others may take liberties and improvise “subrhythms” within a given meter;
and still others may completely resist the musical activity altogether. Whatever formulations the therapist derives about the family’s interactional styles by observing their rhythms provides a useful starting point for understanding the family. These formulations, however, are subject to revision as more information is accumulated. Some examples of deduced clues about interactive style might include: this is a person who demonstrates skill in listening and self-expression; or, this is a person who is resistant and exhibits isolating behaviors; or, this is a person who projects a defiant attitude. Generalizations such as these may either be refined or discarded as the therapy progresses over time.

Finally, music may be experienced in a more compelling fashion than standard dialogue because music stimulates a combination of visual, auditory, and kinesthetic associations. Because of these strong associations, the learning that occurs during a music therapy session is readily accessible and more likely to be retained. These extra cues, in addition to standard “talking” therapy, may help advance the pace of treatment. The experience of music can become a powerful asset to the therapy process because it provides an opportunity to engage the family together in a profound experience, it enhances the impact of the feelings experienced, and it facilitates the recollection of the events that occurred in the session.

Music in Assessment

A useful family assessment provides the therapist with information about family roles, communication patterns, balance of power, and symptoms of dysfunction. As previously noted, the family’s response to rhythm alone may provide valuable information about the members’ communication skills and attitudes toward working together. For example, if a family is intent on maintaining rhythmic homeostasis, it may be especially helpful to understand what the benefits for each family member might be.

A musical assessment of the balance of power within a family can be accomplished by offering the family a selection of instruments and giving them a general task, such as asking everyone in the family to play and to end together. Who takes what role within the family will quickly become apparent. By observing the family
perform a relatively unstructured musical task, the therapist can begin to determine who functions in what manner and to what capacity within the system. Physical placement as well as audible interaction can help cue the therapist as to each member's typical role. Imbalances of power and diffuse boundaries can be detected. For example, a child instructing the parent on how and when to play or a parent instructing or criticizing in a manner that hampers or inhibits a child provides valuable insight into the dynamics of interaction within the family.

Music in Formulation

Prior to intervention, it is necessary to glean an understanding of the dynamics within the family and to construct a formulation as to what is occurring, why, and what function it serves for the family. For example, the therapist may formulate that a teen-age daughter's running away from home functions to assist the mother in avoiding examination of her unsatisfactory marriage. The therapist may "test" this theory by listening to and watching the mother's interaction with father in the music-making. Is the music conjoint or adversarial? What does the music portray about their marital relationship? Does the daughter appear to ally with either parent? Who works together rhythmically, tonally? Who listens to whom? Who follows? Who dominates?

Formulations may be developed in an ongoing manner and revised in response to data gathered in sessions.

Musical Intervention

Once a clinical formulation has been developed that appears to reflect accurately the source of the dysfunction, the therapist can construct musical interventions designed to alter the adverse patterns. A number of musical activities may allow the family to experience a change within the session that can carry over into daily life.

Practicing Self-differentiation (Systemic)

A group music improvisation can provide an opportunity for family members to experience group participation and individu-
ality at the same time. Within the music each member can simultane­ously play their own improvisation and interact with the family unit as a whole. Through repetition of this process, each member can practice new ways of instrumental expression while hearing and responding to the expression of others. This is essentially the Bowenian process of self-differentiation in musical form. Once this is possible in musical form, the feeling of the interaction is achieved and may be replicated in other modalities (e.g., verbal).

*Taking an “I” Position (Systemic)*

A solo improvisation is a unique statement of individual expression at the moment of performance. This is analogous to the Bowenian concept of taking an “I” position. Soloing may be implemented by directing each family member to choose an instrument and play solo for the family. The family is then prompted to applaud each individual’s performance. Acknowledgment by the family conveys both acceptance and appreciation of the sharing.

*Building Congruent Communication (Strategic)*

Musical duets in family therapy address Haley’s concern for communication at the same level. When only two people are playing, it becomes fairly obvious where the musical interaction breaks down. After discussion of the attempt, the therapist (or family members) can make suggestions to help improve the communication, and the members playing the duet can then experiment with new ways of playing together and experience improvement in the session.

*Repairing Communication Breakdowns (Strategic)*

Musical echoing is simply one person playing a short sequence and another person repeating it. (Generally, rhythmic echoing is more suitable than tonal echoing in intra-family interventions. A therapist may reflect a patient’s tonal expression more effectively in an individual music therapy session.)

This type of echoing can help restore communication because it encourages family members to listen and respond to each other
in a validating and nontreatening manner. This experience is essential for work in families where the children's feelings are not validated or perhaps not acknowledged. Likewise, this type of echoing exchange helps to interrupt patterns of blaming, accusing, and shaming that are automatic, unconscious responses. Through the process of echoing musically, family members can develop skills of listening and responding. Both the parents and children can experience the validation of being heard.

**Establishing Boundaries (Structural)**

The therapist may ask the parents to direct their children in a musical activity—from the choice of instruments to how and when to play. If both parents are present, the parents can be instructed to take several minutes for a private “parents meeting” where they will plan how they wish to conduct the activity. The parents can opt to assign specific instruments to the children or give them a limited choice of instruments. They may opt to give specific musical parts or to open the activity to an improvisation. This allows the children (and parents) the experience of the parents acting together as a unit, an experience often missing in the dysfunctional family.

The parents could also be directed to “conduct” the playing and use voice and/or hand signals to direct the children when to start playing, stop playing, increase and lower volume. Following the musical piece, the parents may have another brief “parents meeting” and return to say what they liked and did not like about the piece, and what they would like for the second piece.

**Restructuring Dysfunctional Relationships (Structural)**

Directing a parent to provide a basic rhythm from which the child may improvise establishes the parent as a giver of structure. The child may then be able to experience returning to the safety of the parent's rhythm after exploring on his/her own, as in Mahler's stage of Rapprochement (Mahler, 1965). This may be a critical experience for both child and parent, particularly when severe lack of structure in the family is evident. Exercises such as this one help define and strengthen a parent-child boundary that
has become diffuse, where the parent acts inappropriately or irresponsibly and the child assumes either a caretaking role or peer ("buddy") relationship with a parent.

Case Studies

Case 1

Bob was a depressed 12-year-old Caucasian boy who hated his stepfather and dreamed of moving in with his biological father at grandmother’s house. Although his natural father had a lengthy history of substance abuse and was physically abusive toward Bob’s mother, Bob could see these characteristics only in his stepfather, toward whom he targeted the bulk of his anger. Bob was referred to outpatient therapy due to his social withdrawal in school, suicidal ideation, and aggressive outbursts. He attended weekly individual sessions and bi-weekly family therapy sessions for approximately 7 months.

Bob was accustomed to accommodating Carla, his mother, whenever she requested that he loan her money and, on his own initiative, monitored her violent mood swings and warned his siblings—Carrie, age 8, and Judy, age 5—to be good when she was excessively aggravated and prone to outbursts. He then resented her attempts to discipline him and was particularly angry about having to share the same bedtime as his younger sisters. He felt that his stepfather was unnecessarily mean and wanted mother to get rid of him. Bob felt picked on by his stepfather and said he overheard arguments between mother and stepfather in which he (Bob) was the central point of conflict. He was tired and frustrated by the constant arguing in the house and complained that his sisters were treated better than he. Bob was convinced that he would be much happier living elsewhere.

Formulation

Bob comes from a dysfunctional family system where males are alcoholic, and females are ultra-responsible, co-dependent, and both primary income producers and caretakers. His mother and
biological father divorced when he was an infant. Bob carries resentment that another man is attempting to replace his biological father and further resents that his natural father was abusive to his mother. Bob idealizes his father and defends his father’s addictive behavior.

Boundaries in this family are unclear. Mother disciplines by attempting to reason with the children in the hope that they will be persuaded to her viewpoint. While this kind of approach may be effective in convincing a peer, it is not appropriate for a mother who needs to set limits for her children. When her attempts at reasoning with the children fail, she resorts to yelling, which she perceives as working better for her. With these techniques, mother is relating either as a peer or another child, rather than a parent. This diffuse boundary is exemplified by an incident in which mother borrowed several hundred dollars from Bob (though it was unclear where Bob got the several hundred dollars in the first place) and continued to delay paying it back for various reasons. This was the source of numerous arguments between Bob and his mother, as well as much anger and resentment. Mother astutely noted that she seemed to be relating to her son as she did to her ex-husband. This was a clear example of poor family boundaries.

Treatment objectives

- Development of Bob’s skills in expressing his feelings, needs, desires, and responses to his chaotic family situation.
- Appropriate expression of unverbalized feelings.
- Understanding of the dysfunctional patterns in his family.
- Development of appropriate parent/child behaviors and boundaries in the family.
- Non-argumentative interaction among family members.

Interventions

Several musical interventions with mother and children (minus stepfather) were conducted in family therapy sessions:
• free improvisation
  Free improvisation allowed family members a specific time for unrestricted expression. This helped counter the family's typical pattern of censoring and restricting each other.

• mother taking "conductor" role
  Mother was able to successfully experience parental authority when in the "conductor" role. The children were able to experience appropriate limit-setting.

• individual soloing
  The individual soloing was a favorite intervention for the children in this family. Since each child was fighting desperately for mother's attention in daily life, this actively provided a forum for each child to have a turn at the spotlight, to be listened to, recognized, accepted, and applauded.

• duets with mother
  Duets with mother were particularly effective in compelling mother to listen to one child at a time and respond directly to him or her. This required mother to gain an understanding of the child's expression in order for her to provide accompaniment.

• duets with therapist
  The therapist playing duets with the children was a strategic intervention to model appropriate interaction for mother in a nonthreatening manner.

• boisterous playing/calm playing
  The therapist introduced the activity and allowed the family members their choice of various musical instruments, including conga drum, shakers, afuche (Brazilian shaker with metal beads), electronic keyboard, tabla drum, and bongos. Mother was encouraged to guide the children in choosing instruments and helping them produce some sounds. The family was instructed to play progressively louder and more vigorously while listening to each other and then gradually, while still playing their instruments, to quiet down and play something relaxing. The therapist also participated on the guitar, reflecting the family's changing expressions with chords and melodic lines.
Discussion

This family (minus stepfather) participated in family therapy for approximately 7 months. While only 2 of the sessions incorporated music therapy, those particular sessions created an impact upon the family’s dysfunctional mode of communication. Mother was able to achieve more compliance from the children during the music therapy sessions, possibly due to the natural incentive provided by the appeal of the novel instruments. This setting also afforded mother the opportunity to practice, with live coaching, some of the disciplinary skills she was learning in her individual therapy.

The musical interventions also effectively disrupted the family tendency to rationalize and engage in extended arguments that dominated most of the verbal therapy sessions (with the exceptions of those devoted primarily to the discipline of the younger children when they refused to obey mother). The disruption of rationalization shifted the balance of power away from the children and toward mother.

A particularly significant musical intervention for this family was the playing of the polar emotional states of frenzy and calm. This intervention occurred during a final termination session for which the children had requested music therapy, based on their positive experience with music therapy in a previous session. This strategic intervention incorporated the paradoxical technique of prescribing the symptom. By intentionally creating frenzy, family members demonstrated their ability to control the frenzy by producing it at will. By playing calm, they likewise demonstrated their ability to diffuse the chaos they had produced at will. The playing of boisterous and then relaxing music served several functions for Bob’s family. It dramatically helped de-isolate Bob within the family. He typically placed himself outside of the family bounds both physically and emotionally, though he did maintain an alliance with mother. Within the music, Bob was able to experience acting as part of the family in a constructive way, contrary to the usual blaming and fighting patterns that comprised most of the typical family interaction. The other important function of this intervention was to allow the family the experience of being able to counter anxiety and create an emotionally
calm state out of chaos. Mother was particularly delighted with this activity and gave the children much encouragement for performing well and giving her some peace and relaxation.

The fact that all family members engaged in this particular music therapy session was, in and of itself, a significant change from the patterns of the verbal family therapy sessions. During many of the verbal sessions, the 5-year-old would become distracted and either wander off or demand attention from mother by crying or misbehaving. This typically would shift the focus of the session from Bob’s issues within the family to how mother could begin to appropriately and effectively discipline Judy.

During this musical intervention, however, all family members listened intently to each other and appeared to enjoy working together in this way. Judy became the most vigorous during the frenzied portion of the piece, while mother appeared most satisfied with the playing of calm. While it remained unclear which living environment would be healthier for Bob, through this music therapy session he was able to begin to break the emotional isolation he perpetuated within his family in the Bowenian sense of self-differentiation. In this case, the move closer to his family helped to extricate Bob from his family role as an outcast.

Case 2

Martin was a 29-year-old African-American who was married and had a 10-year-old son. He presented as an emotionally repressed young man. His affect remained flat when discussing the severe consequences he suffered due to his heroin addiction, for which he was currently hospitalized in an inpatient, 28-day drug and alcohol rehabilitation program. Likewise, he displayed little emotion while discussing the circumstances of the death of his parents when he was age 9.

Formulation

Martin has internalized much shame and guilt over his addiction and his behaviors during his addiction, and he is reluctant to share his feelings and opinions with his family. Because he began using drugs in his early teens, Martin never developed adequate skills in communication early in life and his continued drug use
hindered any further advancement in his self expression. He developed an attitude of "I can handle everything myself" at an early age. The drugs also served as an escape from the overwhelming pain of loss around the death of his father. This pain was never directly dealt with and remained as an underlying emotion contributing to Martin's depression.

**Treatment Objectives**

- Begin to develop skills in expressing feelings
- Improve communication with wife
- Acquire addiction/recovery education
- Improve parenting skills

**Interventions**

Though initially resistant to playing musical instruments, Martin had made some progress using music to express a wider range of emotional statements in both individual and group therapy sessions during his hospitalization. In addition to several marital therapy sessions, one family therapy session was conducted with Martin; his wife, Debbie; and their 10-year-old son, Johnny. Debbie was overly verbal to the point of answering questions directed at other family members. She also maintained a nonverbal dialogue with Johnny that consisted of various nods, facial expressions, and hand movements. Martin remained virtually static while his son Johnny launched into a series of penetrating questions about what substances his father used and why. During this barrage, Debbie gave Johnny nonverbal encouragement to continue. Martin continued to respond primarily with one-word answers and, occasionally, a short phrase. To keep Johnny’s attention from getting diverted, his mother promised him, after gaining approval from the therapist, that if he would pay attention through the talking part of the sessions, he could play the conga drum that he had been flirting with. The verbal portion of the session served to provide the family with some information about addiction and to assist them in exploring their feelings (mainly hurts and fears) around Martin’s drug use.

The musical portion of this session was brief but poignant.
When the verbal interaction was finished, Johnny started striking the conga drum and looked to his parents to join him on the various instruments available. The therapist then invited the parents to join in. Both vehemently refused. While the therapist supported Johnny on another drum, Johnny began to strike his conga louder and louder directly in front of his father. Johnny progressed to the point of violently beating on the conga, while mother shouted, "Why are you playing so loud? Are you that angry?" Johnny continued to beat the drum violently until the therapist directed him to stop. When asked why he was playing so loudly and what he was feeling, Johnny stated that he did not know. Martin then took the opportunity to close the session, stating he did not want to miss dinner.

Discussion

This case illustrates how emotions travel within a family system. Martin's inability to express his emotions functioned as a closed faucet. Early in the session, Debbie compensated for Martin's deficiency by over-verbalizing. When both Martin and Debbie shut down at the time of the musical exercise, Johnny became the voice for the whole family. Johnny was the only family member capable of expressing the tremendous anger and frustration that all family members had experienced for a long time during Martin's addiction. Although Debbie could speak prolifically, she always sounded frantic and pressured, and she could not genuinely emote. The prospect of letting go of her verbal defenses was just as scary for Debbie as was Martin's fear of opening up to his feelings, and so neither could engage in the activity with their son. This created a replay of the emotional abandonment Johnny experienced when his father was engaged with drugs and mother's attention was split among Johnny's needs, Martin's addiction, and her own frustration. Martin and Debbie clearly needed additional work on communicating their feelings and parenting together as a unit.

Martin and Debbie's refusal to participate raises a pivotal issue: client resistance to musical intervention. Several strategies to counter and diminish resistance might have been possible in this case, if the sessions were to continue. Since Martin had been progressing in his individual musical work, he may have been
able, over a period of time, to develop enough self-confidence to try a music therapy session with his son in the future. Additional explanation from the therapist about the importance of emotional expression may have helped Martin to overcome some of his fears. Limiting the length of participation time to 5 minutes, or whatever length of time might be tolerable, might be a first step. Since Martin and Debbie were both very concerned about Johnny, they may have responded to an appeal to help him experience positive family communication. If they had consented, further music therapy sessions with Martin's family could have been aimed at developing family members' skills in self-expression, breaking the alliance of mother and son against father, and improving the family's ability to work together and enjoy themselves together as a family.

Summary

While music therapy as a family therapy is at a very young stage of development, it is clear that the possibilities for using music therapy with families are encouraging. As an outgrowth of individual therapy, family therapy brings the integral relationships within the family into the treatment setting. The systemic, strategic, and structural schools of family therapy each offer clinical objectives that may be translated into musical interventions. Musical intervention may then be effective in encouraging self-expression, enhancing family communication skills, and addressing the structural imbalances of power within the family.

A clinical formulation may be generated from an assessment of the dynamics within the family. The formulation postulates a clinical rationale for the family's dysfunction in terms of a system. Interventions may then be constructed to treat the pathology. A variety of musical interventions that are useful to families—including conducting, guiding (children), echoing, soloing, playing duets, and playing of mood themes—can address systemic, strategic, and structural family therapy objectives.

The two case studies presented identify practical uses of musical intervention in family therapy to help achieve clinical goals. The case of "Bob" demonstrates how a family can begin to gain
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some control over their typically chaotic interactions that cause much stress for all. The case of Martin demonstrates graphically how emotions are passed from one person to another within a family system. Martin’s case also brings up issues of resistance to music intervention and how to counter it.

Further clinical practice, exploration, and research will certainly yield innovative and effective techniques in addressing family dysfunction via the vehicle of music therapy.

REFERENCES


Eric B. Miller, M.Ed., CMT-BC, completed his graduate work in substance abuse counseling at Antioch New England in Keene, New Hampshire. He has designed and implemented music therapy programs at the Family Continuity Program in Kingston and on Cape Cod, Massachusetts; at PATH Inc., Philadelphia; and at the Valley Forge Medical Center and Hospital, Norristown, Pennsylvania. Eric has worked as a psychotherapist and music therapist in inpatient, outpatient, and residential settings with adults and children, as well as in private practice. He currently serves as president of Expressive Therapy Concepts, Inc., a nonprofit organization located in Phoenixville, Pennsylvania, dedicated to education and service in the arts therapies.

AUTHOR’S NOTE: I look forward to hearing from other music therapists about how they conduct family sessions and address such issues as addiction, resistance, abuse, and communication disorders, as well as specific and general dysfunction.