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**MUSIC THERAPY:
A STUDY IN PROFESSIONALISATION**

**Katherine Alison Barrington
Submitted for the degree of Ph.D. in the University of Durham
Department of Music, 2005**

Abstract

This thesis focusses on the way in which the music therapy profession in the UK has developed during the period 1958-2003. I have investigated historical information, including archival material, regarding the development of music therapy and drawn upon a number of sociological models in order to explore some of the key concepts of profession. I have interwoven the concepts from these two main sources to provide new and original research. Although I argue that the various aspects of the field are all interlinked, I focus on the manner in which music therapy has interacted with the social and political climate within which it has evolved. I argue that the field of music therapy in the UK has engaged fully in a process of professionalisation which involves complex interactions with other professional bodies, the government, accrediting authorities, employers, clients, and the public. These interactions have, on the one hand, created conflicts within the music therapy profession due, in particular, to outside political pressures. On the other hand this has also compelled the profession to seek a balance between the needs of the discipline and its clients, and the demands of the political climate within which music therapy has to work.

I consider the arguments that the professionalisation of music therapy is detrimental to the creativity and integrity of the field. These criticisms have been directed at the Association of Professional Music Therapists because its work has been based on securing appropriate terms and conditions for practitioners. Although these criticisms offer an opportunity for music therapy in the UK to reflect on its development, I argue that the process of professionalisation has succeeded in spite of all in creating a strong and ethically sound foundation from which music therapy can be practised, and that this process has not been primarily an exercise in professional self-preservation or promotion.

**Music Therapy:
A Study in
Professionalisation**

by

Katherine Alison Barrington

**Submitted for the degree of Ph.D
in the University of Durham
Music Department**

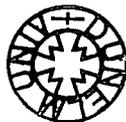
Supervisor

Professor Max H. Paddison

2005

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05 MAY 2006



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Declaration

No part of this thesis has previously been submitted for any degree in this or any other university, and not part of it has previously been published.

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Introduction

Music therapy in the United Kingdom has undergone enormous changes and challenges throughout the second half of the twentieth century. It has developed from being a number of individuals working independently throughout the country to a cohesive group of accredited practitioners. There have been significant developments throughout this time which have supported these transitions. The introduction of two organisations (the Society for Music Therapy and Remedial Music¹ and the Association of Professional Music Therapists) has helped to solidify a supportive network which offers a clear identity for those who practice music therapy around the country.

In this dissertation I explore the development of music therapy in the UK with particular focus on the manner in which the field has gained a professional identity and the extent to which politics has played a part in this process. This development has been achieved through a process of professionalisation and I draw on material from both music therapy and sociology to examine the growth of music therapy in this country in the light of sociological theories of professionalisation. I demonstrate how the Association of Professional Music Therapists has engaged with this process of professionalisation.

Some music therapists have criticised this process suggesting that it is not compatible with an altruistic, client-serving attitude attributed to music therapy. These criticisms, which will be identified in this study, suggest that the process of professionalisation is a self-serving exercise which will, by its nature, take the focus away from the clients. However, I argue that the work undertaken by the Association of Professional Music Therapists to engage with this process has created more stable working conditions for music therapists working in the UK and demonstrates an attitude of professional responsibility. It has been necessary for music therapy in the UK to engage with the process because this has encouraged appropriately accountable practice through which the clients can feel confident about the

¹The Society for Music Therapy and Remedial Music became the British Society for Music Therapy in 1967.

service provided. This is not to say that conflicts have not occurred, but overall the profession has struck a balance between the political pressures placed upon it, the needs of the profession and the interests of the practitioners. I argue that this is a balance which ultimately supports the clients.

This introduction includes definitions of concepts which are used throughout this dissertation. One particularly awkward term needs to be considered now. The term *music therapy profession* is used frequently in a colloquial manner amongst music therapists. In this form it is a general description of the whole body or field of music therapy. It is not used as a technical term to describe music therapy as having achieved professional status. Nor does it express a view that the field of music therapy has engaged in the process of professionalisation as identified by sociological studies. However, because it is so widely used, it would be difficult to avoid the colloquial form of this term without complex and awkward circumlocution. It is, nevertheless, clear when the term is being used in a broad, colloquial manner and when it is being used in a more precise, conceptual sense in the context of the sociology of professions. The theories of the process of professionalisation and professional status are defined in this Introduction.

The Life Span of the Music Therapy Profession

... transformation is not always experienced as a change from one thing *into* another. It can also be felt as a more subtle process, a shift in the overall template for perceiving and understanding the world. In this narrative then, transformation is about the constantly shifting colours, textures, modulations and key changes that compose the many 'contextual scores' of our lives and which, at various moments, offer us the opportunity to see, hear and experience ourselves in new ways.² (italics in the original)

So writes the music therapist David Stewart, who stated that new experiences and new developments will present themselves at opportune moments for individuals, for communities and for professions. In the United Kingdom the modern profession of music

²Stewart, David, 'Narratives in a New Key: Transformational Contexts in Music Therapy,' in *Community Music Therapy*, eds. Mercédès Pavlicevic and Gary Ansdell (London: Jessica Kingsley Publication, 2004), p.281

therapy could be said to have been founded in the middle of the twentieth century.³ I explore the notion that music therapy has been introduced in the UK at a point when the public has accepted its existence.

The growth of the music therapy profession has been described in terms of a life span.⁴ According to Leslie Bunt, during the infancy stage a profession will be needing to create basic rules for survival, such as the establishment of theories and the acquisition of posts. Later on, during the adolescent phase, more experimentation is undertaken such as research projects. Writing in the mid 1990s Bunt was suggesting that the music therapy profession in the UK had reached a late teenage stage in that it had moved beyond the initial experimentation phase, was gaining confidence and had potentially moved beyond internal factions and disagreements. Six years later, Stewart continued the analogy, suggesting that '[as] a profession in evolution music therapy has just undergone a *rite de passage* which sees its "adult status" enshrined in law ... What type of "adult" music therapy will become, and how it will balance the necessary tensions of compliance and non-compliance in relationship with its new "regulatory parents" waits to be seen.'⁵ (italics in the original) In this dissertation I argue that the music therapy profession has had to establish relationships with other professions, regulatory bodies and clients which have been founded on a balance of compliance and non-compliance. Robert Landy put this into context when he wrote:

[a profession] ... needs to retain a self-reflective and critical stance, responsive to changing, emerging and moribund theory and practice, critical of fads and mendacities. It needs to take stock of current political and economic realities and of research and critical thought in related fields of inquiry ... and to develop strategies, forecast future directions and provide a sense of leadership to those who have devoted themselves to healing through the arts.⁶

³The term music therapy within this dissertation refers to the *modern* profession which, I argue, began in the UK with the founding of the Society for Music Therapy and Remedial Music in 1958.

⁴See Bunt, Leslie, *Music Therapy. An Art Beyond Words* (London: Routledge, 1994); Stewart, David, 'The State of the UK Music Therapy Profession. Personal qualities, working models, support networks and job satisfaction,' in *British Journal of Music Therapy* (Vol. 14 (1): 2000), pp.13-31

⁵Stewart, David, 'The State of the UK Music Therapy Profession. Personal qualities, working models, support networks and job satisfaction' in *British Journal of Music Therapy* (Vol. 14 (1): 2000), p.26

⁶Landy, Robert, 'Introduction to Special Edition on the State of the Arts,' in *The Arts in Psychotherapy* (Vol. 24 (1): 1997), p.4

However, I question to what extent the music therapy profession has been able to control its development (regardless of the amount of self-reflection it has engaged in) given the amount of external pressures that are imposed on the arts therapies. Even Ruud offered some reservations regarding the development of music therapy which are pertinent to this thesis:

A politics of music therapy must come to terms with its limitations. It must recognize its interdependence with material and economic forces and align with those forces in society that work toward creating a space for human empowerment, self-insight, personal growth, solidarity, and social networking and with those that work toward alleviating structural forces blocking possibilities of action.⁷

Ruud argued that the field of music therapy has had to engage with other professions, with the government, with employers and with institutions. As such it has needed to learn to recognise which external material and economic forces are going to be compatible with its own integrity. I explore these issues and ask to what extent has the field of music therapy had the opportunity to manage its own growth and development. Has the field of music therapy been buffeted by demands and expectations made on it by those outside music therapy? How has the field of music therapy in the UK coped with these issues? Has it been proactive and been able to create its own path or destiny or has it been reactive and had to respond retrospectively to demands made on it? Cheryl Dileo-Maranto wrote:

In the most basic sense, we have been victimised (but not in a completely negative way) by these [external] influences because they have provided us not only with structure and context on clinical and professional levels, but also with boundaries and limits for what is acceptable and unacceptable. In reality, music therapists from every country have been bound by these external influences, and their impact on practice has been inestimable: thus, it is not unreasonable to assume that music therapy has to a large extent been externally defined in many countries.⁸

To summarise: I attempt to explore to what extent music therapy in the UK has developed autonomously or been driven by demands from external forces and agencies. I chart the

⁷Ruud, Even, *Music Therapy: Improvisation, Communication, and Culture* (Gijsum: Barcelona, 1998), p.5

⁸Dileo-Maranto, Cheryl, 'Crossing Boundaries,' in *Journal of British Music Therapy* (Vol. 8 (1): 1994), p.2

development of the field of music therapy in the UK from the end of the 1950s to the present day.

Methodology and Key Concepts

For this research it has been necessary to draw upon different sources and disciplines in order to offer a clear line of argument. I have drawn on two main sources to support my thesis. Firstly, I have sought to provide a historical perspective of the music therapy profession in the UK and have studied and documented archival material held within the offices of the Association of Professional Music Therapists and the British Society for Music Therapy as well as additional material held in other offices at Anglia Polytechnic University in Cambridgeshire, Harper House in Hertfordshire and Nordoff and Robbins Music Therapy Centre in London. These documents had not been systematically reviewed before. I have also explored historical reviews by music therapists such as Juliette Alvin (1991), Leslie Bunt (1994), Gary Ansdell (2002), and Rachel Darnley-Smith and Helen Patey (2003) and have brought this material together to provide a historical context for this thesis. I have also drawn upon material which has explored the development of complementary medicines with particular reference to the manner in which these fields have gained status within the National Health Service.

Secondly, I have drawn upon a number of sociological models in order to explore some of the key concepts of *profession*. Studies into professionalisation have been primarily conducted by sociologists and I have concentrated on theories by Magali Larson (1977), Eliot Freidson (1970; 1983; 1994), Terence Johnson (1972), Terry Johnson (1995), Gerry Larkin (1995), Donald Light (1995), and Dietrich Rueschemeyer (1983). I have identified a number of different theories but have focussed on the model of the process of professionalisation expounded by Magali Larson. This model argues that occupations progress through a number of different stages in order to develop towards the status of profession. I have taken this as a template from which to view the historical development of the music therapy profession. Thus I have interwoven the historical material of the music therapy profession with sociological models to produce new and innovative research into music therapy.

The amount of research conducted on the *discipline* of music therapy is not mirrored by the amount of research on the *profession* in the UK. A review of music therapy literature emphasises that most publications focus on the discipline of music therapy, on the development or evolution of treatment procedures or theoretical models rather than the profession itself. I suggest that all aspects of the field influence and are influenced by all other aspects. Therefore, the development of the profession works in conjunction with the development of the discipline. This research has only lightly touched on the development of the discipline and has focussed heavily on the profession. Therefore, it could be argued that I am neglecting the interwoven histories of both segments of music therapy. I am aware that I am primarily studying one aspect of the field and could be accused of contradicting my own view that every development within the field of music therapy interacts and impacts on every other development. However, I would argue that much can be taken for granted regarding the knowledge and development of the discipline. It is the *context* and the process of professionalisation that now needs attention. Due to the necessary limitation imposed on this thesis, it is not possible to cover all aspects of the development of music therapy. I suggest that further research needs to be undertaken to explore these connections between the discipline and profession. The focus for this dissertation has been the process in which music therapy in the UK has engaged with the issue of professionalisation. As such, I suggest that this dissertation helps to re-dress the balance between, on the one hand, the research conducted on the discipline itself and, on the other hand, the relative neglect of the profession of music therapy in the UK.

Alan Solomon reminds the prospective researcher that ‘it is the failure to properly delimit the study that often presents the most significant problem for the person attempting a historical research project.’⁹ Through literature reviews I have identified a clear focus for this thesis. Although many of the issues relevant to the development of the music therapy profession in the UK are also relevant to other arts therapies in the UK, there is a substantial amount of music therapy history which is unique and deserves individual attention.

The decision to focus this research on the development of the music therapy profession only within the UK was taken because there are a number of issues which are unique to this

⁹Solomon, Alan L., ‘Historical Research,’ in *Music Therapy Research - Quantitative and Qualitative Perspectives*, ed. Barbara L. Wheeler (Phoenixville: Barcelona, 1995), pp.490-491

country, including the development of the National Health Service and the introduction of music therapy into this institution. Many of the comments made by music therapists from other countries have been noted within this dissertation but, on the whole, the focus has remained on the profession in the UK. There are three main reasons for exploring the professionalisation of music therapy in the UK: the changing attitude towards paramedic treatment; the growing interest by music therapists in the history of music therapy; and the development of Community Music Therapy.

Literature on Complementary Medicine

Since the 1960s there has been a changing attitude towards paramedic treatments which has had an impact on the development of music therapy. Peregrine Horden noted that ‘... a more sensitive, holistic conception of medicine is firmly back in fashion.’¹⁰ Sarah Cant stated that the government, although reluctant, is noting this trend:

... the government ... has now required that all natural therapies ‘get their act together’ and has stated that they [sic] will contemplate statutory regulation if the therapies prove themselves to be united and well trained.¹¹

I consider what has brought about this changing attitude towards complementary medicines and how this might have encouraged the development of the music therapy profession in the UK. I engage with work by Ursula Sharma and Sarah Cant (1996), John Carrier and Ian Kendall (1998), and Mike Saks (1995; 1996; 1998) to explore the balance of power between the orthodox medical profession and the complementary medicines. The art therapist Diane Waller has engaged more specifically with the issues relating to the development of the arts therapies in the UK. She has offered a historical context of the art therapy profession which is closely associated with the music therapy profession. She has also expressed reservations about the compatibility of the arts therapies to the process of professionalisation, and her views have been pertinent for my thesis. She writes:

¹⁰Horden, Peregrine, *Music as Medicine: The History of Music Therapy since Antiquity* (Aldershot: Ashgate, 2000), p.21

¹¹Cant, Sarah, ‘From Charismatic Teaching to Professional Training: The Legitimation of Knowledge and the Creation of Trust in Homeopathy and Chiropractic,’ in *Complementary and Alternative Medicines - Knowledge in Practice*, eds. Sarah Cant and Ursula Sharma, (London: Free Association Publishers, 1996), p.52

Becoming a profession is a political process which involves the persons who are engaging in this process in games, strategies and tactics in the pursuit of aims which one hopes are altruistic. Why did art therapists want to do this when it appears so much at odds with the attitude of an art therapist to encourage honesty, openness and integrity for self and clients? Why is it necessary? When the art therapist has so often identified with the 'outsiders' in our society what is to be achieved and what lost in the process?¹²

Waller suggests that the process of professionalisation entails a journey of self promotion for the profession and the professionals. However, arts therapists want to be perceived to be offering an altruistic service which focusses on the needs of the clients. She considers how these two conflicting attitudes can be worked together. Have the arts therapies followed a path which is too much at odds with their value system and has this left them grappling with a sense of loss of integrity?

Wigram and Woddis wrote that '[d]e-institutionalisation is inherent in the philosophy of art and music therapy practise [sic], and is an integral part of the therapy process.'¹³ This comment refers to the de-institutionalisation of clients. However, the profession of music therapy seems to have become institutionalised because it has joined with other professions to come under the umbrella of the Council for Professions Supplementary to Medicine. The Association of Professional Music Therapists has actively sought involvement with other organisations. This dichotomy appears to echo Waller's comments. The autonomy which the philosophy of art and music therapy encourage for their clients does not seem to be mirrored in the manner in which the profession itself is developing. I argue that the needs of the clients are different from the needs of the profession and explore the issue of professional autonomy in more depth within Chapter Two.

¹²Waller, Diane, 'Come Back Professor Higgins - Arts Therapists need you! The importance of Clear Communication for Arts Therapists,' in *Arts - Therapies - Communication. On the Way to a Communicative European Arts Therapy*. Vol 1. eds. Line Kossolapow, Sarah Scoble, and Diane Waller (Münster: Lit Verlag, 2001), p.246

¹³Wigram, Tony, and Woddis, J., Letter to David Bird (3.4.1986), Document held within APMT archives. File BL:1

Literature on the Professionalisation of Music Therapy

Music therapists in the UK are showing a growing interest in the development and the history of the profession. Since the late 1990s there has been a significant increase in the amount of literature published which has focussed on the history of the profession, the memories of senior music therapists and the needs and the support systems for practitioners.¹⁴ For example, David Stewart undertook research into the professional and personal issues that were having an impact on music therapists in the late 1990s. I suggest that, by its very existence, it offers an insight into a growing interest in the needs of the practising music therapists. He explained that developments such as the acquisition of State Registration and the formalisation of training programmes may have been having a positive impact on the field of music therapy as a whole. However, he expressed a concern that:

in terms of 'filtering down' to the level of working therapists, the positive impact of this improved status was harder to pinpoint. The profession on the ground did not yet appear to have reaped the full benefits of these structural developments, at least not throughout the UK ... my [Stewart's] hypothesis was that the profession as a whole was not in such a healthy 'state of mind.'¹⁵

Stewart described a sense of 'professional isolation [and the] challenges of establishing and sustaining clinical work and some framework of support.'¹⁶ Whilst some areas of the country have numerous potential music therapy posts, other areas are simply not interested in promoting the service. It also seems that those working within the National Health Service

¹⁴See for example, Ansdell, Gary, 'The State We're In,' in *British Journal of Music Therapy* (Vol. 14 (1): 2000), pp.2-4; Hills, Barbara, Norman, Ian, and Forster, Lucy, 'A Study of Burnout and Multidisciplinary Team-working amongst Professional Music Therapists,' in *British Journal of Music Therapy* (Vol. 14 (1): 2000), pp.32-40; Stewart, 'The State of the UK Music Therapy Profession. Personal qualities, working models, support networks and job satisfaction' (2000); Wigram Tony, 'Historical Perspectives Interview Series:' interviewed by Helen Loth in *British Journal of Music Therapy* (Vol. 14 (1): 2000), pp.5-12; Bunt, Leslie, 'Historical Perspectives Interview Series,' in *British Journal of Music Therapy* (Vol. 14 (2): 2000), pp.56-61; Odell-Miller, Helen, 'Historical Perspectives Interview Series,' interviewed by Rachel Darnley-Smith in *British Journal of Music Therapy* (Vol. 15 (1): 2001), pp.8-13; Warwick, Auriel, 'Historical Perspectives Interview Series,' interviewed by Mary Simmons in *British Journal of Music Therapy* (Vol. 15 (2): 2001), pp.44-50; Christophers, Denize, 'Historical Perspectives Interview Series,' interviewed by Helen Tyler in *British Journal of Music Therapy* (Vol. 16 (1): 2002), pp.7-10; Asbridge, Diana, 'Historical Perspectives Interview Series,' interviewed by Mary Simmons in *British Journal of Music Therapy* (Vol. 16 (2): 2002), pp.67-70

¹⁵Stewart, 'The State of the UK Music Therapy Profession. Personal qualities, working models, support networks and job satisfaction' (2000), p.14

¹⁶Ibid., p.13

have many benefits which are not accessible to freelance music therapists or those working within the education sector.

A more recent survey conducted in Britain by Catherine Worsley in 2002 focussed more on the pressures for music therapists within the NHS. She was concerned that, being such a small profession, music therapy could be 'capable of development and strengthening or [it] might ... just "fizzle out."' ¹⁷ The results of her questionnaire suggest that 90% of music therapists who responded were confident that there is a positive future for the music therapy profession.

At the Seventh World Congress Martin Parker-Eames presented a paper on the professionalisation of music therapy. He asked some pertinent and uncomfortable questions regarding the status of music therapy as a profession:

Regardless of the feasibility of ... becoming a profession in the full sense of the word, the issues relating to the occupational place of music therapy are still pertinent. Is it possible or desirable to try to achieve a secure and influential position in healthcare? What compromises would have to be made to achieve this? Are the necessary compromises worth it for the clinicians and for the clients? As the healthcare world becomes more complex and more corporate, and the financial aspects more crucial, these are questions that have to be asked and answered by all the healthy occupations [sic].¹⁸

To date this has been the only article found to deal specifically with the professionalisation of music therapy. However, there is a growing number of papers criticising the concept. Many of these criticisms stem from proponents of Community Music Therapy (CoMT) and I suggest that it is important to understand the issues raised.¹⁹ Although CoMT has been acknowledged as a global phenomenon there is a perception that the UK has played a leading role in its development. Ansdell has written extensively on the subject and has noted

¹⁷Worsley, Catherine, *A National Survey and Overview of Music Therapy within the National Health Service (2001-2002) - What the Therapists Say* (unpublished paper, 2002), p. 1

¹⁸Parker-Eames, Martyn, *Professionalisation of Music Therapy*, paper given at the 7th World Congress of Music Therapy Conference (Vitoria-Gasteiz: 19-23.7.1993) see the website: <http://www.musictherapyworld.net>, p.1275

¹⁹Community Music Therapy will be shortened to CoMT in line with the book, Pavlicevic, Mercédès, and Ansdell, Gary, eds. *Community Music Therapy* (London: Jessica Kingsley, 2004)

that there has been a mixed response to CoMT ranging from 'It's Ridiculous! - Here he [Ansdell] goes again! It (He) needs to be stopped!' to 'We've been doing this for 20 years - What's new?'²⁰ Advocates of CoMT have written about the professionalisation of music therapy which they state has been detrimental to the field. Certainly, the growth of CoMT and the current demands facing music therapy in the UK have given much food for thought for this thesis. Mercédès Pavlicevic sums up the current situation for music therapy in the UK:

The profession of music therapy is now surrounded by other professions (community musicians, remedial teachers, special music educators, recreational workers), whose skills and territories are not that distant from ours. There have also been changes in state policies to do with care, hospitalization, attitudes to rehabilitation and education. The world is not what it was, or where it was, when music therapy first emerged as a modern discipline. We need to 'read the signs of the times' and re-frame ourselves within contemporary currents, not only to be a relevant and responsible profession, but also to re-gain the creativity and daring that our ancestors possessed abundantly, and used generously.²¹

The explosion of literature on CoMT has included much more speculation on the cultural and community contexts in which music therapists work. One reason for this development could be that the field of music therapy has matured enough to become less self-absorbed and to consider its existence in conjunction with the changing needs of society. It might also have reached a stage when it can cope with, and acknowledge, the fractures that have occurred and are occurring within the field. Stewart and Bunt suggest the field of music therapy has reached an adult state during which, according to the sociologist Larson, a profession attains the ability to recognise and work with the larger context, the social, political and cultural contexts in which the profession is placed.

Simon Proctor is also concerned that the music therapy profession has moved under the umbrella of the NHS and has become associated with bio-medical forms of treatment. He suggested that this tactical move is not compatible with the core values of music therapy and

²⁰Ansdell, Gary, *Community Music Therapy 'Big British Balloon' or Future International Trend?* (London: British Society for Music Therapy, 2003), p.2

²¹Pavlicevic, Mercédès, 'Learning from *Thembaletu*: Towards Responsive and Responsible Practice in Community Music Therapy,' in *Community Music Therapy*, eds. Mercédès Pavlicevic and Gary Ansdell (London: Jessica Kingsley, 2004), p.47

he stated that there is a direct clash between the self-preservation of the professional and the needs of the client. He emphasised that the purpose of music therapy is to enable and empower clients and described the way in which some aspects of mental health treatment dis-empower clients by promoting the expert-patient dichotomy: 'The patient, characterised by need and ignorance, is thus in a position of dependent subjugation to the doctor, characterised by knowledge, experience, and expertise.'²²

Proctor stated that the music therapy profession is lacking integrity. Whilst it wants to enable and empower the clients by offering equality and partnership through music, the music therapy profession also wants to promote its knowledge, experience and expertise:

As our profession matures and makes the transition from radical, outsider group to accepted, establishment group through processes such as state registration, we must be aware of the dangers of 'professionalisation.' Preoccupation with rising professional status or eagerness to adopt the assumptions of more established disciplines may compromise our ability to offer clients our distinctive skills.²³

Gary Ansdell posed this question at a symposium entitled 'Music, Healing and Culture: Towards a Comparative Perspective': 'How does the emergence of "music therapy" as a recognized profession fit into wider accounts of professionalization and competing claims for authority within and on the margins of the medical community?'²⁴ Unfortunately according to Ansdell, there was little discussion on the music therapy profession or the professionalisation of music therapy. Until the introduction of Community Music Therapy this topic had attracted very little interest.

Before describing the contents of the chapters, I shall first comment on the two main elements of this study: profession and music therapy. These sections will offer some definitions for the terms to be used throughout this work. I do not offer a comprehensive

²²Proctor, Simon, 'Empowering and Enabling - Music Therapy in Non-medical Mental Health Provision,' in *Contemporary Voices in Music Therapy. Communication, Culture and Community*, eds. Carolyn Kenny and Brynjulf Stige (Oslo: Unipubforlag, 2002), p.97

²³Ibid., p.106

²⁴Ansdell led a discussion forum entitled, 'Music Therapy in the 20th Century: Praxis, Discourse and Discipline,' at the Conference 'Music, Healing and Culture: Towards a Comparative Perspective.' (London: 20-21.8.1997). See Gouk, Penelope, ed. *Musical Healing in Cultural Contexts* (Aldershot: Ashgate, 2000), p.7

list of definitions for such concepts as profession and music therapy. Instead I present working definitions which will be used consistently.

What is Music Therapy?

Given all of the challenges inherent in defining music therapy ... it is very unlikely that a universally accepted or final definition will ever be formulated. Music therapy is too broad and complex to be defined or contained by a single culture, philosophy, treatment model, clinical setting, or individual definer.²⁵

Kenneth Bruscia identified a total of sixty-nine definitions from music therapists and music therapy associations throughout the world.²⁶ Whilst Even Ruud offered a very short and open definition which stated that music therapy is 'an effort to increase possibilities for action,'²⁷ other definitions are longer and more detailed. For example Bruscia offered the following definition:

Music therapy is a systematic process of intervention wherein the therapist helps the client to promote health, using music experiences and the relationships that develop through them as dynamic forces of change.²⁸

Chapter One explores the concept of music therapy more thoroughly, but here I offer these two equally valid definitions for the purpose of this dissertation. It will also be helpful to explore further definitions by Kenneth Bruscia and Brynjulf Stige, as they both help to clarify the whole field of music therapy by dividing it into sections. The American music therapist Kenneth Bruscia offered a distinction between the discipline and the profession of music therapy²⁹ and the Norwegian music therapist Brynjulf Stige divided the field into three: the discipline, the profession and the professional practice.³⁰ These authors recognised

²⁵Bruscia, Kenneth, *Defining Music Therapy*, 2nd edition (Gilsum: Barcelona, 1998), p.17

²⁶See Bruscia, *Defining Music Therapy* (1998), pp.265-277

²⁷Ruud, *Music Therapy: Improvisation, Communication, and Culture* (1998), p.3

²⁸Bruscia, *Defining Music Therapy* (1998), p.20

²⁹Bruscia, Kenneth, 'Professional Identity Issues in Music Therapy Education,' in *Perspectives on Music Therapy Education and Training*, eds. Cheryl Dileo-Maranto and Kenneth Bruscia (Philadelphia: Temple University, Esther Boyer College of Music, 1987), p.26

³⁰See Stige, Brynjulf, *Elaborations toward a Notion of Community Music Therapy* (Oslo: Acta

that research, teaching, training, literature, supervision, conferences and public presentations and workshops are also important aspects of the field.

Since the development of Community Music Therapy, more interest has been placed on re-defining the field of music therapy as a whole. The belief that CoMT is a new strand of music therapy has led Gary Ansdell to describe traditional music therapy as the consensus model.³¹ Definitions of CoMT are not forthcoming and this seems to be a major aspect of the rebellion against the consensus model with all its definitions, theories and techniques. As Ansdell wrote:

Community Music Therapy is an anti-model that encourages therapists to resist one-size-fits-all-anywhere models (of any kind), and instead to follow where the need of clients, contexts and music leads.³²

Brynjulf Stige stated that the term music therapy is a 'reductionist anachronism' because it comes from a specific context, culture, history 'strongly informed by medical perspectives, or at least addressed to communicate to medical contexts':³³

Community Music Therapy is a model of practice, at least not in any narrow meaning of that term. Community Music Therapy is not characterised by a pre-defined set of procedures and techniques, rather by a set of values and basic assumptions.³⁴

The introduction of CoMT offers this thesis a greater insight into the views and opinions of contemporary music therapist on the development of music therapy during the past forty-five years. Proctor leads the way in suggesting that music therapy has lost some of its cutting edge rebelliousness by becoming a recognised and approved profession. Similarly

Humaniora, 2003), pp.221-229

³¹See Ansdell, Gary, 'Community Music Therapy and The Winds of Change - A Discussion Paper,' in *Contemporary Voices in Music Therapy. Communication, Culture, and Community*, eds. Carolyn Kenny and Brynjulf Stige (Oslo: Unipubforlag, 2002), pp.131-136

³²Ansdell, *Community Music Therapy 'Big British Balloon' or Future International Trend?* (2003), p.3

³³Stige, *Elaborations toward a Notion of Community Music Therapy* (2003), pp.212-213

³⁴Stige, Brynjulf, 'Community Music Therapy: Culture, Care and Welfare,' in *Community Music Therapy*, eds. Mercédès Pavlicevic and Gary Ansdell (London: Jessica Kingsley, 2004), p.103

Ansdell and Pavlicevic consider disciplinary procedures, State Registration and professional associations are stifling the creative development of a discipline.³⁵

Pavlicevic and Ansdell's comment highlights that not everyone may be happy with the way music therapy in the UK has developed during the past forty-five years. Proponents of CoMT are rebelling against the professionalisation and the institutionalisation of the traditional models and these arguments will be addressed throughout this dissertation. At this point I shall simply offer some observations on the discipline, the profession and the professional practice of music therapy.

The Discipline, the Profession and the Professional Practice of Music Therapy: Identifying the Differences

Although I will focus on the process of professionalisation of music therapy in the UK I argue that the three aspects of the field of music therapy (profession, professional practice and discipline) identified by Stige cannot be completely separated from each other. At this point it is necessary to clarify what is meant by these three elements and I offer arguments from Bruscia and Stige. Kenneth Bruscia has been instrumental in considering the issue of definitions within the field of music therapy and he explored the broad issue of music therapy as both a discipline and a profession:

The conceptual struggle is to recognize identity differences between the *discipline* of music therapy and the *profession* of music therapy. The discipline is an organized body of knowledge pertaining to the therapeutic applications of music; the profession is an organized group of people who work in the field. Thus, when conceptualized as a discipline, our identity is defined by the range of therapeutic applications music has, and our role boundaries are determined by the knowledge we have of them. When conceptualized as a profession, our identity is defined by our job titles and responsibilities, and our role boundaries are determined by the qualifications (and salaries) that others impose upon us.³⁶ (emphasis in the original)

³⁵Pavlicevic, Mercédès, and Ansdell, Gary, 'Introduction, The Ripple Effect,' in *Community Music Therapy*, eds. Mercédès Pavlicevic and Gary Ansdell (London: Jessica Kingsley, 2004), p.28

³⁶Bruscia, 'Professional Identity Issues in Music Therapy Education' (1987), p.26

Bruscia continued his line of enquiry by suggesting that the discipline of music therapy is *field-independent* in contrast to the profession which he describes as *field-dependent*. He stated:

When we define our identity in terms of the discipline, we are 'field-independent' - we are who we are because of what *we* know about what we do. When we define our identity in terms of the profession, we are 'field-dependent' - we are what we do, and what we do is based on what *they* know. When we are field-independent, our major task is to educate ourselves; when we are field-dependent our major task is to educate others. Herein lies the developmental struggle. Music therapy is struggling to exert its own identity at a stage of development when perceptions of others are still important. Hence, we are unable to be entirely field-independent or field-dependent. Our identity is being co-developed. The identity we give ourselves influences and is influenced by the identity given to us by others.³⁷ (*italics in the original*)

Bruscia's definition of the music therapy profession touches on the core issue of this thesis, namely the question of how much the music therapy profession in the UK has been able to create its own path of development and how much of its development has been subjected to external demands. According to Bruscia the discipline of music therapy is separate enough to retain a certain amount of autonomy, and it is the profession of music therapy that has been most influenced by external factors. I explore this point, employing theories from sociologists such as Freidson, Larson and Johnson and questions to what extent the field of music therapy in the UK has been balancing between autonomy and external demands. This is a central theme within this dissertation. The music therapy profession has lost some of its autonomy because it has been asked to provide evidence of efficacy. I argue that it is the responsibility of the music therapy profession to create an attitude of transparency and accountability despite the potential loss of autonomy. I agree with Freidson's theory³⁸ that all work which impacts on the clients must be open to scrutiny and not field-independent.

Stige is keen for the discipline to remain separate from what he perceives to be the more politicised areas of music therapy. This would allow the discipline to remain autonomous from external pressures. Stige states that the training courses are forced to consider the

³⁷Ibid., p.26

³⁸See Freidson, Eliot, *Profession of Medicine. A Study of the Sociology of Applied Knowledge* (New York: Dodd/Mead, 1970)

political issues (such as maintaining standards, producing high pass rates, and offering modules that are in line with national standards) which, in turn forces the students to acquire specific skills in order to get jobs. This negates the opportunity to learn about the discipline of music therapy purely for the purpose of acquiring knowledge. He states:

If the discipline of music therapy is linked too closely to the profession of music therapy and defined by the needs as they are seen from, say, the professional associations, a critical and constructive potential is lost.³⁹

Stige writes that 'music therapy as discipline is the study and learning of the relationship between music and health'⁴⁰ and states that there is a need for music therapy and music and health to be studied freely and away from external influences. In this field-independent environment the purpose of the studying would be for the development of knowledge and not for the advancement of a professional or political agenda. However, Stige notes that the discipline is connected to the profession and to professional practice:

A profession is not only principally linked to a discipline or an interdisciplinary field, it is also practically and politically linked to a society, through informal and formal regulations of roles and responsibilities.⁴¹

Whilst I will comment primarily on the development of the profession of music therapy, the issue of the interconnectedness between the discipline, the profession, and professional practice will be explored throughout the dissertation.

Stige offers a definition of music therapy as professional practice: 'Music therapy as professional practice is situated health musicking in a planned process of collaboration between client and therapist.'⁴² This view of professional practice emphasises the practical

³⁹Stige, *Elaborations toward a Notion of Community Music Therapy* (2003), p.221

⁴⁰Stige, Brynjulf, *Culture-Centered Music Therapy*, (Gilsun: Barcelona 2002), p.198

⁴¹Stige, *Elaborations toward a Notion of Community Music Therapy* (2003), p.215

⁴²Stige, *Culture-Centered Music Therapy*, (2002), p.200. The term *musicking* has been defined by the musicologist Christopher Small thus: 'To music is to take part, in any capacity, in a musical performance, whether by performing, by listening, by rehearsing or practicing, by providing material for performance (what is called composing), or by dancing.' Small, Christopher, *Musicking*, (Hanover: University Press of New England, 1998), p9, cited in Ansdell, Gary, 'Rethinking Music and Community: Theoretical Perspectives in Support of Community Music Therapy,' in *Community Music*

application of the knowledge held within the discipline of music therapy. Stige distinguishes professional practice of music therapy from the profession of music therapy which he describes thus:

Music therapy as profession is a community of scholar-practitioners who have a recognized training and competence qualifying for a social role, with specific obligations and rights in relation to clients, colleagues, other professions, and the public.⁴³

All these definitions are offered as a basis for the conceptual framework for this dissertation. It is also necessary to consider the differences between the thesis by Stige and my argument. Stige's thesis is based on the idea that music therapy needs to be more culture-centred and more community-centred. He explores the concepts of culture and community and how music therapy can place itself within the cultural contexts in which it finds itself. Whilst his thesis explores political issues, it focusses more on the discipline and the professional practice of music therapy. I am investigating the extent to which politics has played a part in the development of music therapy in the UK and what is meant by the concept of a process of professionalisation in this concept.

To put it another way, Stige explores the meta-theories that make up the discipline of music therapy as well as the knowledge and practical ability to cope with the changing needs and demands of communities and clients (and he offers case studies as examples). He concludes that Community Music Therapy is a response to the changing attitudes towards health, culture and music in the twenty-first century which are not willing to conform to one, definitive theory or model.

I investigate the manner in which the field of music therapy has created opportunities for music therapists to collaborate with each other as well as other professionals and professional organisations. The music therapy profession in the UK has formed Associations, one of which has come under the umbrella of other organisations to consider the formalisation and institutionalisation of the field. I consider such questions as: What has

Therapy, eds. Mercédès Pavlicevic and Gary Ansdell (London: Jessica Kingsley, 2004), p.70

⁴³Stige, *Elaborations toward a Notion of Community Music Therapy* (2003), p.224

brought about these developments? Has the music therapy profession in the UK needed to collaborate with other organisations in order to grow? What might have instigated the rebellion against these developments in the form of CoMT? I argue that it is necessary to understand the political issues that have impacted on the development of the music therapy profession in the UK.

So far the idea of the professionalisation of music therapy has been greatly neglected and yet music therapists seem keen to analyse and understand all other areas of the field. If the discipline, the professional practice and the profession impact on each other I have argued that, particularly with the growth of CoMT, it is time for some research into the profession. Therefore, it is necessary to consider some definitions of profession and the process of professionalisation.

Profession: A Problem of Definitions

Defining the concept of profession can often cause confusion. The terms profession, professional, professionalism, can be used both technically and colloquially and this is one main source of difficulty. For example, Gordon Horobin explains that the word professional can be used colloquially to describe the manner in which a job has been done.⁴⁴ Thus a job undertaken by an amateur is sometimes described as professional because it has been executed skilfully. However, Eliot Freidson suggests that technically what 'makes the activity "work" is its exchange value. What makes a performer a "worker" or a "professional" is his relationship to the market.'⁴⁵ But, as Horobin pointed out, even unpaid or amateur activities can have financial implications. For example an amateur sports person has some value to his/her sponsors and there have been cases in which unpaid workers (such as housewives) have sought financial compensation in court. This confusion between the paid and unpaid worker will not be a concern for this dissertation as the term music therapist

⁴⁴Horobin, Gordon, 'Professional Mystery: The Maintenance of Charisma in General Medical Practices,' in *The Sociology of the Professions. Lawyers, Doctors and others.* eds. Robert Dingwall and Philip Lewis (London: Macmillan Press, 1983), p.89

⁴⁵Freidson, *Profession of Medicine. A Study of the Sociology of Applied Knowledge* (1970), p.17

used throughout will be applied only to those who are fully qualified and who are paid for their work.

Magali Larson wrote that professionalism ought to focus on service ideal rather than economic gain and a desire to create 'a service which they themselves believe in.'⁴⁶ Terence Johnson defined professional jobs as those of producers who 'define both the needs of the consumer and how those needs should be met.'⁴⁷ I will explore the difficulties that have faced the music therapy profession when balancing between a service ideal and economic gain, noting that music therapists tend to work with vulnerable clients, dependent on the good will of the therapists. Freidson offered a definition based on the ideal of service and altruism:

[professionalism is] a set of attributes said to be characteristic of professionals. It is said to include such attitudes as commitment to one's work as a career so that one's work becomes part of one's identity and an emphasis on public service rather than private profit.⁴⁸

Another issue is the difficulty in attempting to define a profession in comparison with an occupation. Geoffrey Millerson stated that a profession is an occupation wanting to achieve higher status:

To achieve professional status, the occupation must be subjectively and objectively recognized as a profession ... recognition can take the form of high remuneration, delegation of responsibility or authority etc ... It is a type of higher-grade, non-manual occupation, with both subjectively and objectively recognized occupational status, possessing a well-defined area of study or concern and providing a definite service, after advanced training and education.⁴⁹

⁴⁶Larson, Magali, *The Rise of Professionalism: A Sociological Analysis* (California: University of California Press, 1977), p.58

⁴⁷Johnson, Terence, *Professions and Power* (London: Macmillan, 1972) cited in Cain, Maureen, 'The General Practice Lawyer and the Client: Towards a Radical Conception,' in *The Sociology of the Professions. Lawyers, Doctors and others.* eds. Robert Dingwall and Philip Lewis (London: Macmillan Press, 1983), p.108

⁴⁸Freidson, *Profession of Medicine. A Study of the Sociology of Applied Knowledge* (1970), p.70

⁴⁹Millerson, Geoffrey, *The Qualifying Associations. A Study in Professionalization* (London: Routledge and Kegan Paul, 1964), pp.9-10

Freidson offered this suggestion:

... it is useful to think of a profession as an occupation which has assumed a dominant position in a division of labor, so that it gains control over the determination of the substance of its own work. Unlike most occupations, it is autonomous or self-directing.⁵⁰

Some sociologists have felt Freidson's theory of the autonomy of professions to be naive. Larson wrote about this issue suggesting that 'prestige and autonomy flow "naturally" from the cognitive and normative bases of professional work.'⁵¹ In this thesis I investigate how Larson's theory can be applied to the music therapy profession in the UK. For example, I question to what extent the profession has developed training programmes and State Registration to gain prestige and autonomy (as she suggested) and to what extent these developments have been advanced for the protection of the clients/public.

Different theories have used other terms to attempt to highlight a hierarchy of professions, describing some as full-professions and others as semi-professions. The distinction between these two types is as hazy as that between occupations and professions. According to Nina Toren the full professions have been established for longer than the semi-professions and include medicine and law.⁵² Semi-professions have been founded more recently and include social workers, nurses, therapists and teachers who tend to work within larger organisations. Rather than considering a clear distinction between full and semi-professions it may be easier to view them on a continuum and to identify the issues that are pertinent to all professions. For example, Etzioni considered whether professions were working within or independently from larger organisations, the demographics of full and semi-professions, and the extent to which professions were able to work autonomously or were subject to demands from other authorities. Etzioni's research highlighted the fact that semi-professionals tend to be employed women who work within organisations and who are less likely to work

⁵⁰Freidson, *Profession of Medicine. A Study of the Sociology of Applied Knowledge* (1970), p.xvii

⁵¹Larson, *The Rise of Professionalism: A Sociological Analysis* (1977), p.xi

⁵²See Toren, Nina, 'Semi-professionalism and Social Work: A Theoretical Perspective,' in *The Semi-Professions and Their Organization. Teachers, Nurses, Social Workers*, ed. Amitai Etzioni (New York: The Free Press, 1969), pp.141-195

autonomously.⁵³ William Goode stated that members of full professions tend to be more committed to remaining within their profession than semi-professionals because they are a more homogeneous group and have a greater control over their disciplinary procedures.⁵⁴

This section has offered an overview of only some of the issues identified within the literature of professions. These will be explored in more detail with specific reference to the music therapy profession in the UK in Chapter Two. It is necessary at this stage, however, to offer an overview of two types of sociological studies on professions, namely trait theory and the process of professionalisation.

Trait Theory and Critical Responses to the Trait Theory

In 1964 Geoffrey Millerson published an analysis of various definitions of profession which demonstrated that there were certain characteristics sociologists argued were essential for professions. He was aware that each independent study might have had a particular bias which could colour a definition and it seems that, by combining twenty-one such studies, he felt able to provide a more generic analysis and definition of the traits which could constitute any and all professions. Millerson's list offered the six most commonly noted traits of professions:

- a) A profession involves a skill based on theoretical knowledge.
- b) The skill requires training and education.
- c) The professional must demonstrate competence by passing a test.
- d) Integrity is maintained by adherence to a code of conduct.
- e) The service is for the public good.
- f) The profession is organized.⁵⁵

Millerson recognised that the six main traits identified do not in themselves constitute a profession. Whilst he focussed primarily on internal organizational structures, he accepted

⁵³See Etzioni, Amitai, ed. *The Semi-Professions and Their Organization. Teachers, Nurses, Social Workers* (New York: The Free Press, 1969)

⁵⁴See Goode, William, 'The Theoretical Limits of Professionalization,' in *The Semi-Professions and Their Organization. Teachers, Nurses, Social Workers*, ed. Amitai Etzioni (New York: The Free Press, 1969), pp.266-313

⁵⁵Millerson, *The Qualifying Associations. A Study in Professionalization* (1964), p.4

that becoming a profession was a process involving flexible and ever-changing relationships with clients and society as a whole.

Subsequent sociologists criticized this narrow perception held by trait theorists. Rue Bucher and Anselm Strauss argued that this style of study viewed a profession only as a cohesive and generally homogenous community and neglected to acknowledge the more controversial conflicts which can occur within a profession.⁵⁶ Bucher and Strauss specifically focussed on the issue of diversity and investigated how different segments within the medical profession cope with diversity and change.

Freidson also rejected Millerson's positivistic research⁵⁷ because he stated that a profession needed to be viewed as a *folk concept* which exists within a community. He considered the concept to be complex and criticised the trait model because it failed to consider broader contexts in which professions exist. He wrote that '[o]ne cannot study profession without definition guiding one's focus any more fruitfully than one can study structure without a definition.'⁵⁸ Furthermore he argued that:

The future of profession lies in embracing the concept as an intrinsically ambiguous, multifaceted folk concept, of which no single definition or no attempt at isolating its essence will ever be generally persuasive.⁵⁹

⁵⁶See Bucher, Rue, and Strauss, Anselm, 'Professions in Process,' in *American Journal of Sociology* (Vol. (66): January, 1961), pp.325-334

⁵⁷Positivism 'was originally employed by Auguste Comte (1798-1857), the founding father of the discipline of sociology, which he modeled on the empirical principles of natural sciences of his day, in opposition to theology and metaphysics, as a rational science of society ... Comte writes: "the first characteristic of the positive philosophy is that it regards all phenomena as subjected to invariable natural laws. Our business is ... to pursue an accurate discovery of those laws, with a view to reducing them to the smallest possible number."' Comte, Auguste, cited in Kenneth Thompson ed. *Auguste Comte: The Foundation of Sociology* (London: Nelson, 1976), p.43 cited in Max Paddison, 'Immanent Critique or Musical Stocktaking? Adorno and the Problem of Musical Analysis,' in *Adorno: A Critical Reader* eds. Nigel Gibson & Andrew Rubin (Oxford & Malden, Mass.: Blackwell Publishers, 2002), p.230

⁵⁸Freidson, Eliot, *Professionalism Reborn; Theory, Prophecy and Policy* (Chicago: University of Chicago Press, 1994), p.15

⁵⁹Freidson, Eliot, 'The Theory of Professions: State of the Art,' in *The Sociology of the Professions. Lawyers, Doctors and Others.* eds. Robert Dingwall and Philip Lewis (London: Macmillan Press, 1983), p.32

Terence J. Johnson also criticised the trait model noting that it did not take into consideration the fact that professions and their relationships within society are in a constant state of flux and that a list of traits offers only a static, historically specific and culturally bound overview of the concept.⁶⁰ Thus, the three main criticisms of the positivistic studies on professions could be summarised thus:

1. Positivistic studies do not take account of the internal struggles and arguments that exist within professions.
2. Positivistic studies do not take account of the communities in which professions exist.
3. Positivistic studies do not take account of the ever-evolving relationships between professions and clients and the state. They offer static, historically bound and culturally specific views of professions.

Some of the literature on music therapy from the USA has aimed to produce lists and statistics on the music therapy profession which suggests that there was a desire to define the profession by identifying specific traits. For example, a study conducted by Donald E. Michel identified the professional profile of practising music therapists.⁶¹ Similarly, a survey conducted by Leo Shatin, Wallace Kotter and Gladys Douglas-Longmore offered a view of the personality traits which constituted a 'successful' music therapist.⁶² However, their results did not comment on how the personality traits of a music therapist could effect a community or a client group. These studies by Michel and Shatin *et al.* gave views of the profession of music therapy within a very specific time and space, thus failing to take into account the needs of the clients or the political demands of the state. Furthermore the emphasis of the study by Shatin *et al.* is on the 'successful' therapist which side-steps any negativity within music therapy.

⁶⁰See Johnson, Terence, *Professions and Power* (London: Macmillan, 1972), pp.23-29

⁶¹See Michel, Donald, 'Professional Profile: The NAMT Member and his Clinical Practices in Music Therapy,' in *Journal of Music Therapy* (Vol. 4: December 1965), pp.124-129

⁶²Shatin, Leo, Kotter, Wallace, and Douglas-Longmore, Gladys, 'Personality Profile of Successful Music Therapists,' in *Journal of Music Therapy* (Vol. 5: December 1968), pp.111-113

Surveys of this kind were not limited to the 1960s. Indeed, surveys carried out in both the UK and the USA from the 1960s to the present day⁶³ have produced very specific and useful information. Nonetheless these have not considered the broader context in which music therapy services are conducted. I suggest that some of the criticisms of the positivistic, sociological studies of the 1960s can also be applied to the music therapy surveys mentioned above.

Process of Professionalisation

[to] speak about the process of professionalisation requires one to define the direction of the process, and the end-state of professionalism toward which an occupation may be moving.⁶⁴

The literature studied has highlighted that the theories on profession and professionalisation have evolved and changed throughout the years. However, the various theories on professionalisation have tended to explore similar issues such as professional autonomy, accountability, monopolisation, market control and knowledge.⁶⁵ These issues have preoccupied the Association of Professional Music Therapists for many years. However, there has been no formal investigation on the manner in which music therapy has engaged with the process of professionalisation in the UK.

Magali Larson wrote about the process of professionalisation suggesting that there is a specific path which an organisation or occupation will follow in order to attain professional

⁶³For example Braswell, Charles, Decuir, Anthony, and Jacobs, Keith, 'Job Satisfaction Among Music Therapists,' in *Journal of Music Therapy* (Vol. 26 (1): 1989), pp.2-17; Cohen, Nicki S., and Behrens, Gene A., 'The Relationship between Type of Degree and Professional Status in Clinical Music Therapists,' in *Journal of Music Therapy* (Vol. 39 (3): 2002), pp.188-208; Stewart, 'The State of the UK Music Therapy Profession. Personal qualities, working models, support networks and job satisfaction' (2000); Hills, Norman, and Forster, 'A Study of Burnout and Multidisciplinary Team-working amongst Professional Music Therapists' (2000) ; Worsley, *A National Survey and Overview of Music Therapy within the National Health Service (2001-2002) - What the Therapists Say* (2000)

⁶⁴Freidson, 'The Theory of Professions: State of the Art' (1983), p.21

⁶⁵See for example, Millerson, *The Qualifying Associations. A Study in Professionalization* (1964); Bucher, and Strauss, 'Professions in Process' (1961); Johnson, *Professions and Power* (1972); Freidson, Eliot, *Professionalism Reborn; Theory, Prophecy and Policy* (1994); Freidson, *Profession of Medicine. A Study of the Sociology of Applied Knowledge* (1970); Johnson, Terry, 'Governmentality and the institutionalization of expertise,' in *Health Professions and the state in Europe*, eds. Terry Johnson, Gerry Larkin and Mike Saks, (London: Routledge, 1995), pp.7-24; Larson, *The Rise of Professionalism: A Sociological Analysis* (1977)

status.⁶⁶ I shall investigate the extent to which the music therapy profession in the UK has followed the predestined path outlined by Larson. Keith MacDonald summarised Larson's view of the process of professionalisation by offering the order in which specific issues will become relevant to an organisation as it moves through the maturation stages towards the status of profession:

1. Starting point - ie. creation of a 'formal organisational group.'
2. Overall objective of the 'organisation' - the desire to pursue a project.
3. Sub-goals - Establishment and maintenance of a market.
Accredited training courses.
Monopolisation of professional knowledge.
Respectability.
4. An 'organisation' will want to work with allied professionals.
5. An 'organisation' will begin to recognise the wider context - social, political, cultural - in which it is working.⁶⁷

Larson's theory does not consider the needs of the client within the process of professionalisation. As such her theory gives the impression that occupations engage in the process of professionalisation for their own gains and not for the good of the clients. She wrote:

Professionalization is ... an attempt to translate one order of scarce resources - special knowledge and skills - into another - social and economic rewards. To maintain scarcity implied a tendency to monopoly: monopoly of expertise in the market, monopoly of status into a system of stratification.⁶⁸

Diane Waller's concern that the process of professionalisation could be seen as incompatible with the ethos of art therapies has already been noted and I ask whether the music therapy profession has indeed travelled down a path towards professionalisation without paying attention to the needs of the client, preferring to focus on the promotion of music therapy itself. Comments made by the authors of recent articles on CoMT seem to suggest that

⁶⁶Larson also offers a list of general points which are pertinent to the process of professionalisation. The list is as follows: collective project, market control, structure (of the profession), body of knowledge (techniques and skills), market of the service, national or international variables, history, social structure, economic developments, politics, ideology and cultural traditions. See Larson, *The Rise of Professionalism: A Sociological Analysis* (1977), pp.49-50

⁶⁷See MacDonald, Keith M., *The Sociology of the Professions* (London: Sage, 1995)

⁶⁸Larson, *The Rise of Professionalism: A Sociological Analysis* (1977), p.xvii

music therapists in the UK are becoming more concerned with the current state or professionalisation of music therapy in this respect.

The Structure of the Dissertation

This dissertation examines the development of the music therapy profession in the UK and the manner in which it has engaged with a process of professionalisation. In order to research the concept of profession it has been necessary to draw on sociological theories. These theories have offered a clearer understanding of the fundamental issues which have underpinned the growth of the music therapy profession in the UK. Because the field of music therapy has become involved with the NHS, I also include research into the developments and policy changes within the NHS.

The research also includes an overview of the field of music therapy in the UK from the late 1950s to the beginning of the twenty-first century. The primary sources used for this research have been archival material from the Association of Professional Music Therapy (APMT) and the British Society for Music Therapy (BSMT). This material includes minutes of all Annual General Meetings, documents on policy changes and letters written to Members of Parliament and professional bodies. Research on this archival material has been vital in building up a picture of how the APMT has established support structures for music therapists. Other material drawn upon has included the growing number of books and articles on the various approaches to music therapy.⁶⁹

⁶⁹Other sources which have given historical information include Alvin, Juliette, *Music Therapy* (London: John Claire Books, 1975); Bunt, Leslie, and Hoskyns, Sarah, 'A Perspective on Music Therapy Research in Great Britain,' in *British Journal of Music Therapy* (Vol. 1 (1): 1987), pp.3-6; Bunt, *Music Therapy. An Art Beyond Words* (1994); Wigram, Tony, Rogers, Penny, and Odell-Miller, Helen, 'Music Therapy in the United Kingdom,' in *Music Therapy: International Perspectives*, ed. Cheryl Dileo-Maranto (Pipersville: Jeffrey Books, 1993), pp.573-604; Waller, Diane, *Becoming a Profession: The History of Art Therapy in Britain 1940 - 1982* (London: Tavistock/Routledge, 1991); Tyler, Helen, 'The Music Therapy Profession in Modern Britain,' in *Music as Medicine: The History of Music Therapy since Antiquity*, ed. Peregrine Horden (Aldershot: Ashgate, 2000), pp.375-393; Gouk, ed. *Musical Healing in Cultural Contexts* (2000); Bunt, Leslie, and Hoskyns, Sarah, eds. *The Handbook of Music Therapy* (Hove: Brunner-Routledge, 2002); Ansdell, 'Community Music Therapy and The Winds of Change - A Discussion Paper' (2002)

Prior to a chronological exploration of the development of the music therapy profession in the UK, Chapters One and Two investigate more fully the concepts and theories of music therapy as well as the sociological theories on the process of professionalisation.

In Chapter One I explore the debates that have occurred within the music therapy profession at the end of the twentieth and the beginning of the twenty-first centuries with particular reference to the concerns that have arisen over the manner in which the music therapy profession in the UK has engaged with the process of professionalisation.

Chapter Two explores how a profession can attempt to distinguish itself from an occupation and the reasons why an occupation might want to become a profession. A profession's desire to gain autonomy whilst retaining trust from the public and the state is a key element in Freidson and Larson's theories on the process of professionalisation. Sociological studies also note that a profession will develop specialist knowledge in order to secure its place within society. I consider how the music therapy profession in the UK has attempted to clarify its own specialist knowledge, has been able to hold on to professional autonomy and has retained the trust of the public and the government.

Finally this chapter considers the theories of Johnson, Larkin, Light and Saks who argue that the relationship between the professions and the government are more symbiotic than Friedson and Larson have described. The music therapy profession has been seeking the approval of the government since the 1970s particularly through its links with the NHS and this is explored in depth throughout the whole dissertation.

Chapters Three, Four and Five examine the history of the music therapy profession in the UK with reference to issues which have impacted on the profession at different stages in its development. Rachel Darnley-Smith and Helen Patey have divided the history of the music therapy profession in the UK into three specific phases. They offer an overview of the profession from 1958 (which is when the Society for Music Therapy and Remedial Music was founded) until 2003 and divide these years into three sections thus: 1958-1976; 1976-1990; and 1990-2003. They justify their decision as follows:

The early years (1958-76) involved setting up the profession out of the work of lone individuals, through the development of organisations and the inception of training courses which helped to define music therapy in the UK. In the next phase (1976-90) the profession was required to satisfy the terms of statutory bodies such as the Department of Health and the academic institutions who validated the training courses and awarded research degrees. Recognition of the APMT as the representative body was essential to these areas of development. The third phase (1990 to ... [2003]) has seen music therapists becoming actively involved at a statutory level by joining together with the other arts therapy professions to create a seat at the Health Professions Council, the state regulatory body.⁷⁰

Thus Chapter Three explores the music therapy profession from 1958-1976 and focuses on the events leading up to, and the issues surrounding, the founding of The Society for Music Therapy and Remedial Music, the importance of the founding of an organisation, the introduction of professional training courses and the overall growth of the modern music therapy profession in the UK during this period.

Chapter Four investigates the profession from 1976-1990 with particular attention to the introduction of the Association of Professional Music Therapy and the work it undertook to attempt to secure recognition by the NHS and the government and to gain firm pay and conditions from the Whitley Council. These developments included the recognition of standards within the profession and this chapter clarifies the differences between *standards* and *standardization*.

Chapter Five investigates the profession from 1990-2003 with particular reference to the demands for accountability, Continuing Professional Development and the links that the music therapy profession has made with other allied professions. The development of Community Music Therapy is explored again in the Conclusion with specific reference to the debates that have surrounded this new growth in the field of music therapy. The Conclusion draws together the material explored and considers the wider implications for the development of the music therapy profession in the UK at the beginning of the twenty-first century.

⁷⁰Darnley-Smith, Rachel, and Patey, Helen M., *Music Therapy*, (London: Sage Publications, 2003), p.23

Chapter One: Music therapy and its Relationship to other Disciplines and Professions in the UK

In this chapter I will focus on two main debates which have occurred within the field of music therapy in the UK during the period 1999-2005 and the aspects of these discussions which have specific implications for the issue of professionalisation.

The first debate was instigated by an article written by Elaine Streeter¹ in which she queried the practice of certain music therapists. She considered that one model of music therapy did not employ appropriate techniques with which to analyse the work involved. However, the music therapists who responded to Streeter's article suggested that she had not fully considered the issues involved.² It is Kenneth Aigen's response that is most pertinent for this dissertation because it argues that music therapy ought to shed its need to borrow theories from other disciplines. In his view a mature discipline should have developed its own indigenous theories and have moved beyond the need to employ techniques created by other disciplines.

The concept of an autonomous music therapy discipline is explored as this mirrors my argument regarding the autonomy of the profession of music therapy. I suggest that the profession has had to establish relationships with other professions and that, not only is it not possible, it is also unethical for the profession to be fully autonomous. In this chapter I agree with Bruscia's view that the whole field of music therapy is neither fully independent from nor fully dependent on demands made by external influences and I also suggest that

¹Streeter, Elaine, 'Finding a Balance between Psychological Thinking and Musical Awareness in Music Therapy Theory - a Psychoanalytic Perspective,' in *British Journal of Music Therapy* (Vol. 13 (1): 1999), pp.5-20

²Aigen, Kenneth, 'The True Nature of Music-Centred Music Therapy Theory,' in *British Journal of Music Therapy* (Vol. 13 (2): 1999), pp.77-82; Ansdell, Gary, 'Challenging Premises,' in *British Journal of Music Therapy* (Vol. 13 (2): 1999), pp.72-76; Brown, Sandra, 'Some Thoughts on Music, Therapy, and Music Therapy,' in *British Journal of Music Therapy* (Vol. 13 (2): 1999), pp.63-71; Pavlicevic, Mercédès, 'Thoughts, Words and Deeds: Harmonies and Counterpoints in Music Therapy Theory,' in *British Journal of Music Therapy* (Vol. 13 (2): 1999), pp.59-62

the developments within the discipline of music therapy impacts on the profession of music therapy.

This discussion covers many different points of tensions between different models of music therapy in the UK and I will offer an overview of these issues which will give relevant background information for this dissertation. However, I will focus primarily on the areas which have a bearing on this thesis with particular reference to the manner in which the field of music therapy in the UK interacts with other disciplines and professions.

The second debate to which I refer in this chapter has emerged with the introduction of Community Music Therapy.³ This second debate also raises concerns about the autonomous nature of music therapy. Proponents of CoMT are critical of the way in which a blanket use of pre-defined techniques, without careful consideration of the unique and individual needs of each therapeutic situation, negates the core value of music therapy, namely the spontaneous, creative playfulness of the discipline.

A number of proponents of CoMT have specifically included the issue of professionalisation within their articles⁴ and have argued that the consensus model of music therapy has engaged with the process of professionalisation which has stifled the creative attitude of music therapy by creating formal standardisation. According to this theory, to standardise the work negates the unique nature of each therapy setting. Therefore, the concept of providing music therapy in a uniform manner, without considering the individual needs of the clients and the unique context within which each therapeutic relationship is established, fails to value each client. I explore these criticisms and also the concerns that have been raised by some music therapists regarding the introduction of CoMT. Although concern about professionalisation has been raised by proponents of CoMT, very little research has

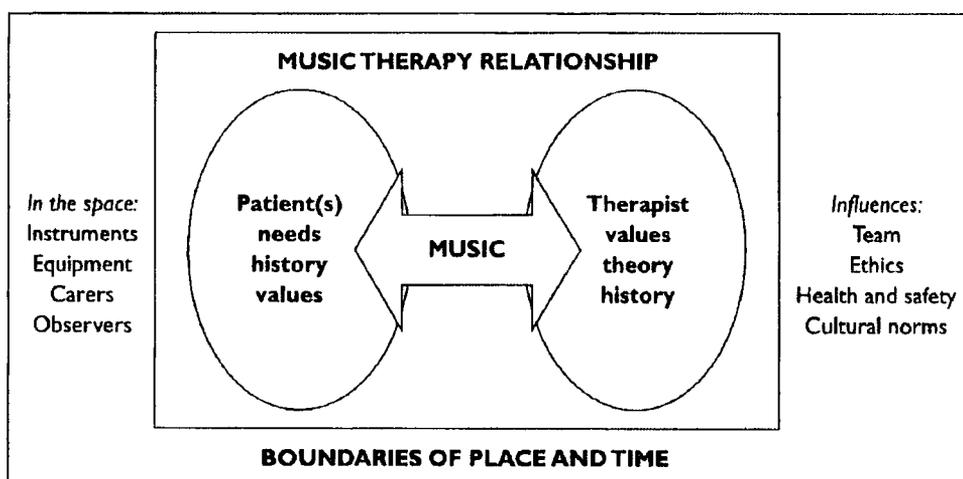
³Community Music Therapy is a relatively new concept within music therapy in the UK and it is because of its development that the term consensus model has been introduced to describe the older, traditional models of music therapy and to distinguish it from CoMT. These terms will be used throughout this dissertation.

⁴See for example, Proctor, 'Playing Politics: Community Music Therapy and the Therapeutic Redistribution of Music Capital for Mental Health' (2004); Stige, *Elaborations toward a Notion of Community Music Therapy* (2003); Pavlicevic, Mercédès, and Ansdell, Gary, 'Introduction, The Ripple Effect' (2004)

been undertaken to explore this issue more fully and I suggest that some of the criticisms have not been adequately considered.

I begin by exploring the debate between Streeter, Aigen *et al.* which highlighted different opinions within the consensus models of music therapy in the UK. Streeter expressly criticised one model of music therapy suggesting that it was ethically unsound and could lead to dubious therapeutic practice. This debate considered to what extent it is appropriate to work with theories from other disciplines in contrast to attempting to develop an indigenous music therapy approach.

Streeter explored the differences between Creative Music Therapy and psychoanalytically-informed music therapy. However, it is too simplistic to consider that there are only two distinct models as all music therapists will interpret the theories and techniques differently. Bunt explained that there is a 'complex interaction of so many variables involved in any piece of therapeutic work'⁵ and Bunt and Hoskyns offered this diagram⁶ to demonstrate the various elements that are involved within a music therapy setting:



⁵Bunt, *Music Therapy, An Art Beyond Words* (1994), p.179

⁶Bunt, Leslie, and Hoskyns, Sarah, 'Practicalities and basic principles of music therapy,' in *The Handbook of Music Therapy*, eds. Leslie Bunt and Sarah Hoskyns (Hove: Brunner-Routledge, 2002), p.27

Each of the elements identified in this diagram interacts with each of the other elements to enable unique experiences to occur within each music therapy situation. Therefore, no one music therapy session is the same as any other because the relationship between the client(s) and the therapist is a dynamic one that requires constant flexibility, analysis and interpretation. The manner in which each music therapist analyses and interprets the sessions will depend on the theoretical and practical approach of the therapist. Bunt and Hoskyns also recognised that each therapist will have his or her own value systems and histories which impact on the therapeutic work.

However, because Streeter wrote a critical article on the differences between the psychoanalytically-informed approach and the Creative Music Therapy approach, it is necessary in this chapter to focus on these two models and offer brief explanations of these approaches to music therapy. The phrases, music *as* therapy and music *in* therapy, were coined by the American music therapist Kenneth Bruscia in 1987⁷ and they describe very succinctly these two approaches of the consensus model in the UK. The music *in* therapy approach uses music within the broader context of therapy and may employ theories from other professions. Psychoanalytically-informed music therapy can be described as belonging to this camp. Music *as* therapy can be used to describe the work undertaken by Paul Nordoff and Clive Robbins. In the late 1960s and early 1970s Nordoff and Robbins came to Britain to help establish a training course which developed their own unique approach to music therapy called Creative Music Therapy.⁸

Historically these two approaches have focussed on different theories of analysis and interpretation. Although Paul Nordoff and Clive Robbins only worked with children successive generations of therapists trained within the Nordoff-Robbins centres have also

⁷Bruscia, Kenneth, *Improvisation Models in Music Therapy* (Springfield: Charles Thomas, 1987), pp.8-9

⁸See Nordoff, Paul, and Robbins, Clive, *Creative Music Therapy, Individualized Treatment for the Handicapped Child* (New York: John Day Company, 1977). The terms Creative Music Therapy and Nordoff-Robbins therapy are commonly interchanged. This dissertation will use the term Creative Music Therapy to describe the approach and Nordoff-Robbins trained therapist to describe music therapists trained in this model.

been working with adults, some of whom have been self-referring clients. This has altered the theoretical perspectives of the Creative Music Therapy model and this has had an impact on the relationship between the two approaches.

Streeter's article can be seen to have opened up a line of discussion which had been long overdue amongst the music therapists in the UK. The debate considered many issues including questioning to what extent the discipline of music therapy is, or should be, dependent on external factors or influences and to what extent it is autonomous. It is this issue which is most pertinent to this dissertation and will be explored most fully in this chapter.

Music *in* Therapy

In her article on the critical differences between Creative Music Therapy and psychoanalytically-informed music therapy Streeter stated:

It is important that music therapy embraces a variety of psychological theories, psychoanalysis being just one of many, in order to help therapists think about the relevance of their client's music and their own music in relation to the client so that musical experiencing can be guided in relation to therapeutic objectives.⁹

Streeter is a proponent of psychoanalytically-informed music therapy. Stewart's survey on the working life of music therapists discovered that the majority of music therapists in the UK describe their work as psychoanalytically-informed.¹⁰ One particular model was developed by Mary Priestley called Analytical Music Therapy. According to Stewart's survey this is not a style which is frequently employed in the UK but it will be described here because it demonstrates clearly the concept of music *in* therapy.

Mary Priestley worked with two colleagues, Peter Wright and Marjorie Wardle in the 1960s, and developed Analytical Music Therapy which uses psychotherapeutic techniques

⁹Streeter, 'Finding a Balance between Psychological Thinking and Musical Awareness in Music Therapy Theory - a Psychoanalytic Perspective' (1999), p.13

¹⁰See Stewart, 'The State of the UK Music Therapy Profession. Personal qualities, working models, support networks and job satisfaction' (2000). However, it needs to be remembered that at the time of writing, all the training courses teach a psychoanalytic approach.

such as transference¹¹ and countertransference.¹² Other psychotherapeutic techniques used in this model for accessing the unconscious include the use of imagery and the exploration of defence mechanisms such as resistance. During Analytical Music Therapy sessions the client and therapist take some time at the beginning of each session to talk with each other to identify an issue or problem concerning the client. During this verbal section the client and therapist may have jointly identified an image associated with the client's issue. The client and therapist spend the second half of the session playing music based on this image and the therapist and client verbally explore the process at the end of the music section.¹³

Analytical Music Therapy has aligned itself to psychoanalysis in its choice of therapeutic techniques but not in the execution of these techniques. Priestley wrote that Analytical Music Therapy 'is not psychoanalysis' because she stated 'unlike in analysis there is a lively, emotional reciprocity.'¹⁴ Within more traditional psychoanalysis there is an expectation that the therapist will refrain from entering into dialogue with the client. However, a music therapist will actively engage with the clients' music by playing music together.

Analytical Music Therapy is not, Priestley said, 'a type of music lesson. The results of successful music therapy should be looked for in the quality of the patient's life and being,

¹¹Bruscia offered the following definition of transference which he suggested is not the only definition but offers a 'broad, inclusive definition ... : A transference occurs whenever the client interacts within the ongoing therapy situation in ways that resemble relationship patterns previously established with significant persons or things in real-life situations from the past. Implicit is a replication in the present of relationship patterns learned in the past and a generalization of these patterns from significant persons or things and real-life situations to the therapist and the therapy situation. Essentially, the client reexperiences in the present the same or similar feelings, conflicts, impulses, drives and fantasies as she did with significant persons or things in the past while also repeating the same or similar ways of handling and avoiding these feelings, persons, and situations.' Bruscia, Kenneth, 'The Many Dimensions of Transference,' in *The Dynamics of Music Psychotherapy*, ed. Kenneth Bruscia (Gilsum: Barcelona, 1998), p.18

¹²Bruscia also offered the following working definition for countertransference: 'Countertransference occurs whenever a therapist interacts with a client in ways that resemble relationship patterns in either the therapist's life or the client's life. Implicit is a replication in the present of relationship patterns in the past, a generalization of these patterns from one person to another and from real-life situations to the therapy situation, the casting of the client and/or therapist within the past relationship, and a reexperiencing of the same or similar feelings, conflicts, impulses, drives, and fantasies through identification.' Bruscia, Kenneth, 'Understanding Countertransference,' in *The Dynamics of Music Psychotherapy*, ed. Kenneth Bruscia (Gilsum: Barcelona, 1998), p.52

¹³See Priestley, Mary, *Essays on Analytical Music Therapy* (Phoenixville: Barcelona, 1994)

¹⁴Ibid., pp.5-6

and not in the improvement of the quality of her musical improvisation or performance.’¹⁵ Priestley added that ‘Analytical Music Therapy does not always aim at instantly producing good experiences, as it is often necessary to work through the emotionally painful blockages before going forward with one’s development.’¹⁶

The clients who make use of Analytical Music Therapy need to be verbal and have some ability to be insightful. The music, whilst vital, is only part of the process as a whole and, as such, it is a clear example of music *in* therapy. The therapist needs to be aware of how each client uses the time and will consider whether the client is finding the verbal or musical parts more useful or whether they are using the words or the music to avoid other parts of the work.

As stated, this chapter has included an overview of Analytical Music Therapy because it offers this thesis a clear and very particular example of music *in* therapy. Streeter perceived that some Nordoff-Robbins trained music therapists could be working in a neglectful manner if they did not employ theories from other disciplines. Music therapists who responded to Streeter’s criticisms explained that her comments showed a lack of full understanding. However, before exploring this debate, it is necessary to offer some background information on Creative Music Therapy with specific reference to the acceptance or rejection of the use of theories from other disciplines.

Music as Therapy

In 1974 another music therapy course was established at the Goldie Leigh Hospital inspired by the music therapists Paul Nordoff and Clive Robbins. The model of music therapy taught on this course was called Creative Music Therapy and it differed from the psychoanalytically-informed approach undertaken by Juliette Alvin and Mary Priestley.

Paul Nordoff and Clive Robbins created an approach to music therapy which resisted incorporating techniques from established therapeutic models preferring to develop their

¹⁵Ibid., p.5

¹⁶Ibid., p.4

own theories without being influenced by others. Nordoff and Robbins met in 1958 whilst Robbins was working at Sunfield's Children Home, a Rudolf Steiner school in Britain. Nordoff, an accomplished professional pianist who had been living in an anthroposophical community in New York State, visited the Home, became fascinated by the potential value of music for children with learning difficulties, and joined forces with Robbins. They travelled and worked throughout America developing their own unique style of music therapy.

Nordoff and Robbins believed that producing music is a highly motivating experience that can help a client find, explore and develop his or her healthy core. They labelled this healthy core the Being Child.¹⁷ According to them this Being Child needs to be nurtured to overcome what they conceive as the Condition Child. This Condition Child has developed as a result of imposed difficulties which have inhibited the child's healthy core. According to Nordoff and Robbins the healthy Being Child can be accessed through the development of the Music Child.

The focus for Nordoff and Robbins was on motivating the clients, encouraging and directing positive musical participation and expecting hard work and commitment. Clive Robbins accepts that both he and Nordoff had 'a certain tendency to have judgmental attitude towards behaviors [sic] that were stemming from pathology. Not because they were inappropriate socially, but because they were standing in the way of the child's self-realisation.'¹⁸ During an interview with Kenneth Aigen, Robbins talked about their theories and reminisced about one client:

I think we were avoiding relating to Loren cognitively, but instead were focussed on engaging him actively and affectively through music. It is almost that we are impatient with Loren's 'old self' (Condition Child) and wanted to press ahead with his Music Child and its strongly implied healthy potential - and to create a new self - in which the Being Child is securely implanted.¹⁹

¹⁷See Nordoff, and Robbins, *Creative Music Therapy, Individualized Treatment for the Handicapped Child* (1977). All the clients that Nordoff and Robbins worked with were children, hence their references to Being Child, Music Child and Condition Child.

¹⁸Aigen, Kenneth, *Paths of Development in Nordoff-Robbins Music Therapy* (Gilsum: Barcelona, 1998), pp.44-45

¹⁹Ibid., p.121, quoting Robbins in an interview with Aigen.

Nordoff and Robbins were extremely diligent in analysing the music but were clear that they did not want to interpret verbally the therapeutic process. Whilst all contemporary Nordoff-Robbins trained music therapists are still committed to the analysis of the music some have questioned the lack of verbal interpretation.²⁰ All Nordoff and Robbins' clients were children with learning disabilities. Contemporary Nordoff-Robbins trained therapists now also work with adult clients who may be verbal and who may also have referred themselves to music therapy. This change in clientele has impacted on the therapeutic processes which Nordoff-Robbins trained therapists may use.

Psychoanalytically-informed music therapists use theories from other, more established therapies and Bruscia calls this work music *in* therapy. Some Nordoff-Robbins trained therapists conceive of music *as* therapy²¹ focussing on the idea that the experience of the music contains the process of therapy without the need to employ non-musical analysis. Nordoff and Robbins themselves did not look towards other therapeutic theories for guidance. However, as the Creative Music Therapy model has developed there has been growing diversity of opinions and attitudes towards the inclusion of external theories and techniques.²²

The Debate Between Streeter, Ansdell, Aigen, Brown and Pavlicevic

Elaine Streeter was concerned that the Creative Music Therapy approach failed to include specific techniques and theories from other disciplines. She considered that this could lead to dubious therapeutic practice. In particular she stated that the analysis of music therapy sessions needed to include verbal interpretation. In order to analyse sessions as fully as possible she suggested that it is important to use words and that the benefits of 'translating'

²⁰See Turry, Alan, 'Transference and Countertransference in Nordoff-Robbins Music Therapy,' in *The Dynamics of Music Psychotherapy*, ed. Kenneth Bruscia (Gilsum: Barcelona, 1998), pp.161-213

²¹See for example, Ansdell, Gary, *Music for Life. Aspects of Creative Music Therapy with Adult Clients* (London: Jessica Kingsley, 1995) and Lee, Colin, *Music at the Edge: The Music Therapy Experiences of a Musician with AIDS* (London: Routledge, 1996)

²²See Aigen, *Paths of Development in Nordoff-Robbins Music Therapy*, (1998)

the work into words offers extra levels of interpretation which might be missed if the therapist simply analyses the music.

Streeter went further to suggest that the therapeutic process may be unsafe if words are not employed and she queried the work of one Nordoff-Robbins therapist by saying that '[w]ithout psychological thinking in balance with musical awareness he [the therapist] was unable to maintain the therapeutic boundaries.'²³ She continued in her article by saying that '[n]othing can be gained by denying the importance of psychological theory in understanding music therapy encounters. Music alone is too flexible and subtle a medium from which to base therapeutic theory.'²⁴ Furthermore, Streeter argued that, even if words are not employed with the client within the session, the analysis of the sessions and the thought processes of the therapist are achieved through verbal processing. Streeter's article caused a flurry of responses and heated debates ensued. Ansdell noted in his dissertation:

there is a sense of the debate sometimes being conducted within a quasi-moral discourse. People talk of the ethics of professional boundaries. In identifying as a music therapist several people speak of 'responsibility' and of the 'appropriateness' of working a certain way (and by implication *not* another way). A more extreme version of this discourse rests on the 'safety/danger' dyad: therapists stating that they feel 'safe' working one way, and of the possible 'danger' of the other.²⁵

Ansdell questioned whether processing a musical experience through words is appropriate or even possible. He suggested that it is the music which defines the specialist nature of music therapy and wondered whether music therapists need to be ' "trusting" the music to get beyond the words.'²⁶

One year after this debate Fraser Simpson explored the use of words within sessions undertaken by Nordoff-Robbins trained therapists.²⁷ Although Simpson recognised that

²³Streeter, 'Finding a Balance between Psychological Thinking and Musical Awareness in Music Therapy Theory - a Psychoanalytic Perspective' (1999), p.9

²⁴Ibid., p.18

²⁵Ansdell, Gary, *Music Therapy as Discourse and Discipline. A Study of 'Music Therapist's Dilemma.'* PhD Thesis (London: City University, 1999), pp.252-253

²⁶Ibid., p.253

²⁷Simpson, Fraser, 'Speaking with Clients Perspectives from Creative Music Therapy,' in

some Nordoff-Robbins therapists use words as part of the therapeutic process there are other Nordoff-Robbins therapists who are reticent to use any words, preferring to continue to analyse only the music within sessions. He stated that, due to the growing number of clients who are fully verbal, it is important to recognise the reality that clients will want or need to talk. Simpson noted that words can be used before, during or after sessions and that at any point they can either facilitate or hinder the therapeutic process. He concluded by stating that 'caution needs to be exercised ... in reality the use of words can no more be standardised than the use of music techniques.'²⁸

Despite the different theories on analysis and interpretation the Creative Music Therapy and psychoanalytically-informed approaches to music therapy have much in common as professional practices. Both accept the need for clear and clinical analysis of sessions and both focus primarily on offering the individual (whether in private, one to one sessions or groups) the opportunity to 'increase [their own] possibilities for action.'²⁹

In the UK during the early 1970s when the Guildhall School of Music and Drama and the Nordoff-Robbins training courses were being established there were clear divisions between the two approaches. Jean Eisler remembered that Alvin felt threatened by the 'very clinically guided work'³⁰ of Nordoff and Robbins. Closer examination of contemporary approaches to music therapy highlights that there is a rich mixture of different models and styles of work. Whilst Nordoff and Robbins themselves tended to work with children with special needs more recent Creative Music Therapy work has included verbal adults. Nordoff and Robbins did not want to employ techniques and theories from other disciplines. However, the acknowledgement and use of transference and countertransference by many Nordoff-Robbins trained therapists contradicts this view.³¹

British Journal of Music Therapy (Vol. 14 (2): 2000), pp.83-92

²⁸Ansdeell, *Music Therapy as Discourse and Discipline. A Study of 'Music Therapist's Dilemma'* (1999), p.91

²⁹Ruud, *Music Therapy: Improvisation, Communication, and Culture* (1998), p.3

³⁰Eisler, Jean, 'Historical Perspectives Interview Series,' interviewed by Rachel Verney in *British Journal of Music Therapy* (Vol. 13 (2): 1999), p.45

³¹See Turry, Alan, 'Transference and Countertransference in Nordoff-Robbins Music Therapy,' in *The Dynamics of Music Psychotherapy*, ed. Kenneth Bruscia (Gilsum: Barcelona, 1998), pp.161-213

Kenneth Aigen also responded to Elaine Streeter's criticisms and his comments are more pertinent to this thesis. His argument focussed on the appropriateness of employing theories from other disciplines:

every area of human inquiry begins by adopting explanatory models and theories from other disciplines ... [y]et, the sign of a mature discipline is one which develops its own explanatory mechanisms, models and theories. My belief is that it is music-centred music therapy which best represents this indigenous form of theory and which is the line along which music therapy theory will develop into a mature and autonomous discipline. If the history of science shows anything it is that the borrowing of explanatory models from an external domain, while a developmentally necessary step, must eventually be abandoned to the creation of indigenous theory.³²

Whilst Aigen stated that a fully mature discipline should not need to rely on expertise from other disciplines Streeter suggested that borrowing technical knowledge from other sources is not a transitory stage for music therapy but one which needs to be recognised as a valid and potentially permanent arrangement.³³ Aigen suggested that the theory of music therapy ought to be independent from external influence.

To abandon the use of theories from other disciplines could give the impression of a mature discipline that has successfully developed its own working theory. I argue that Aigen's theory of a field-independent, mature discipline can have an impact on the status of the profession of music therapy. By developing an indigenous theory the discipline could gain more autonomy and might not be subordinated by any other discipline. Music therapy could then demonstrate that it is offering a unique service. As such, it would have created a market for itself, rather than be perceived as a subsection of another discipline.

Aigen focused on the discipline and did not comment on the issue of music therapy as a profession directly. In this dissertation I argue that all aspects of the field of music therapy

³²Aigen, Kenneth, 'The True Nature of Music-Centred Music Therapy Theory,' in *British Journal of Music Therapy* (Vol. 13 (2): 1999), p.79

³³I suggest that the esoteric knowledge of music therapy, which is only knowable by successfully trained professionals, could be described as a combination of a variety of different techniques (which are also employed in different circumstances by other professions) which, *when combined and employed by trained music-therapists within clinical settings*, constitute a-unique application-of-these skills and techniques to produce the discipline of music therapy at the current time in the UK.

are linked to each other. Therefore, the issues that impact on the discipline also impact on the other aspects of the field.³⁴

Bruscia also considered the issue of dependence and independence for the field of music therapy within which he also recognised the connection between the discipline and the profession. He stated that 'we are unable to be entirely field-independent or field-dependent. Our identity is being co-developed. The identity we give ourselves influences and is influenced by the identity given to us by others.'³⁵ Similarly Jane Edwards argues that 'music therapy is always a socio-political work - in simple terms, what we do with our clients and their families in turn effects our society simply by being part of the warp and weft of the fabric of our community behaviour.'³⁶

Proctor suggests that the consensus model's use of pre-defined procedures and the borrowing of techniques from other disciplines has been done in order to offer a perception of a confident profession:

Since the 1970s ... there has been a gradual restricting of what is and is not considered to be 'music therapy', particularly in the UK. This has coincided with a period of professionalisation, and it is understandable that at such a time music therapy has been trying to convince the world of its professional status by claiming rigorous and clearly defined ways of working ... This portrayal is propagated initially via training courses and subsequently via professional regulation.³⁷

He suggests that music therapy within the consensus model has become a narrow and highly specialised field which has planned its development in order to create a perception of a thriving profession. I suggest that Aigen's theory for the development of an indigenous theory is not based on a desire to try 'to convince the world of its professional status by

³⁴However, in this dissertation I shall not be exploring the ways in which the discipline, practice and professional issues within the field of music therapy impact on each other and suggest that this could be the subject of subsequent research.

³⁵Bruscia, 'Professional Identity Issues in Music Therapy Education' (1987), p.26

³⁶Edwards, Jane, online *Voices: A World Forum for Music Therapy*, (6.8.02) see the website, http://www.voices.no/discussions/discm4_02.html. [part of an online discussion in an electronic journal on a website]

³⁷Proctor, Simon, 'Playing Politics: Community Music Therapy and the Therapeutic Redistribution of Music Capital for Mental Health,' in *Community Music Therapy*, eds. Mercédès Pavlicevic and Gary Ansdell (London: Jessica Kingsley, 2004), p.225

claiming rigorous and clearly defined ways of working' but driven by a desire for the field of music therapy itself. I argue that any developments within the discipline of music therapy will have an impact on the profession and that Aigen's vision of a mature discipline also helps to provide a perception of a thriving profession.

This aspect of the debate between Streeter and Aigen *et al.* links into a more recent debate regarding the introduction of Community Music Therapy. Stige explained that 'Community Music Therapy is not characterised by a pre-defined set of procedures and techniques, rather by a set of values and basic assumptions.'³⁸ This does not negate the use of pre-defined theories (whether theories from other disciplines or theories that are indigenous to music therapy) but, because each situation is unique, the use of pre-defined theories cannot be predicted. Each therapy situation needs to be developed independently from any other therapy situation.

Community Music Therapy

Definitions are needed ... for the development of professional identity and as tools in the process of critical discussion and reflexivity ... [it] becomes important in certain time intervals, as social and cultural changes in a society alters the relationship between disciplines and professions ... To my judgment, the emerging area of Community Music Therapy has created a situation in which the question of how to define music therapy gains renewed relevance and importance.³⁹

Brynjulf Stige suggested that CoMT could offer health care a unique practice based on an innovative theory. He also questioned the core values held within the discipline, the professional practice and the profession of the consensus model and perceived that the creation of standards and the standardisation of the work has stifled the very nature of music therapy. Ansdell's definition of CoMT is worth repeating:

Community Music Therapy is an anti-model that encourages therapists to resist one-size-fits-all-anywhere models (of any kind), and instead to follow where the need of clients, contexts and music leads.⁴⁰

³⁸Stige, 'Community Music Therapy: Culture, Care and Welfare' (2004), p.103

³⁹Stige, *Elaborations toward a Notion of Community Music Therapy* (2003), p.211

⁴⁰Ansdell, *Community Music Therapy 'Big British Balloon' or Future International Trend?*

Stige questions the terminology used within the field. For example, he felt that the term *conscientious care* might be more appropriate than therapy and treatment.⁴¹ He also stated that *music and healing* offered a broader definition than therapy.⁴² His theories lead away from a specific definition of music therapy towards a broader view of how music therapy might be practised.

According to the advocates of CoMT definitions stifle the work and they will not impose one definition on the broad spectrum of projects conducted under the umbrella of CoMT. Articles written about CoMT do not tend to offer definitions but give explanations through case studies of the work which is reminiscent of the music therapy publications of the 1960s-1980s. The emphasis is on the idea that each case is unique.

However, it would appear that CoMT is not rejecting the use of techniques and procedures from other disciplines if they seem relevant and appropriate to a specific situation. What advocates of CoMT do state is that, to attempt to create standard techniques that can be re-used for a variety of similar therapeutic situations, is devaluing the unique nature of each therapeutic relationship. Articles on CoMT stress the desire to move away from attitudes of conformity which has, in the view of the authors, crept into the field of music therapy. Stige also considered the idea of music therapy as a cultural and historically specific phenomenon:

... taken to the extreme, one could ask: Is it even possible to develop a general description of areas of music therapy, or are such areas relative to the historical and cultural context of practice? That is, should we rather speak of *arenas and eras of practice* than of areas of practice?⁴³ (italics in the original)

Since Stige offered a number of case studies from around the world it seems more relevant for this dissertation to concentrate on the development of CoMT in the UK. The

(2003), p.3

⁴¹See Stige, *Elaborations toward a Notion of Community Music Therapy* (2003), p.224

⁴²Ibid., p.231

⁴³Ibid., p.232

development of CoMT in the UK has been sensitive to issues which are specific to this country.

Community Music Therapy in the UK

The explicit aim of Community Music Therapy is to take people from *therapy* to *community*.⁴⁴ (italics in the original)

Like Stige, Ansdell has wanted to broaden out the concept of music therapy. He suggests that, at the turn of the twenty-first century, the term music therapy has come to mean something very specific. The field of music therapy has formalised its knowledge and skills to such an extent that, not only is it offering a very particular kind of service, but also it may have become too inflexible and narrow a field to react to the varying needs of the clients. Ansdell wrote about the development of music therapy in the UK thus:

Music Therapy and its pioneers initially maintained a flexible balance between individual and communal work, but the trend in the last two decades has increasingly been towards a narrower (one might even say *privatized*) practice - as the underlying theoretical model shifted to a psychoanalytic one. It could also be argued that music therapy has developed more as a *therapist* profession than a musician's in recent years - part of the overall process of professionalisation and institutionalisation of music therapy.⁴⁵ (italics in the original)

In Ansdell's view, the consensus model has moved consistently towards emphasising psychoanalytic work with individual clients. Whilst this may be a useful model for some clients, he questioned to what extent the consensus model has lost sight of a broader spectrum of work. Ansdell noted that community musicians have also been working within health organisations and institutions but have been offering clients a very different sort of musical experience. Although there is little theoretical literature to support the work of community music Ansdell offered a definition by Atkinson:

Community Music is a participatory music-making activity in which the community musicians work with a given community to enable them to make music which is

⁴⁴Ansdell, *Community Music Therapy 'Big British Balloon' or Future International Trend?* (2003), p.11

⁴⁵*Ibid.*, p4

inspired by their own interests and ideas. Some Community Music activities seek to address the issues of social difficulty experience by the participating communities, whilst others pursue music-making for its own sake.⁴⁶

Community musicians tend to work with groups within a community. However, music therapists have also offered group work and it is necessary to understand what community musicians and music therapists (working within the consensus model) offer before exploring the particular contribution of CoMT.

Group Work

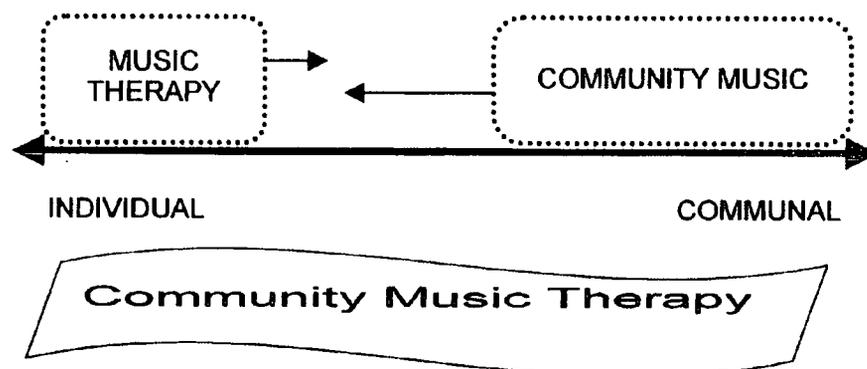
Groups that are established for consensus model music therapy tend to consist of a number of individuals who have been brought together because of a similarity in their needs or disabilities. As such they may not constitute a pre-existing group of people but are a number of separate individuals who may (or may not) be dealing with similar issues. The aim of the work is to help each individual attain a greater *potential for action* within their own lives within the context of group work. Often the group is founded by the therapist or the organisation rather than at the instigation of the clients themselves.

Group work within consensus model music therapy and community music have tended to offer different focuses for clients. Whilst the former has concentrated on the potential growth for each individual the latter has aimed to support performances which are often client led rather than led by the professional. The idea of musical performances is not perceived to fit well into the consensus model primarily because traditional music therapists prefer to focus on the process of therapy rather than a goal or end product implied within the concept of performance. However, proponents of CoMT have concerns that the consensus model of music therapy fails to consider that the clients themselves may want to include performance in their therapy and that this may be a useful part of the therapeutic process. According to this point of view, the consensus model does not offer the flexibility to engage with this concept and will only consider entering a therapeutic relationship on the therapists' terms.

⁴⁶Atkinson, J., *Survey of Community Music in the UK* (unpublished report for the Speedwell Trust, 2001), p.17 cited in Ansdell, 'Community Music Therapy and The Winds of Change - A Discussion Paper' (2002), p.116

CoMT aims to work with pre-existing groups and hopes to improve the *potential for action* of the group or community as a whole and not the individuals per se. It may be that, as a result of these sessions, the individual group members may also increase their *potential for action* but the focus of CoMT work is for the benefit of the community. This concept offers something different from both community music and the consensus model of music therapy because the focus is on the development of the community which is seen as an entity in its own right. Both community music and the consensus model of music therapy may be focussing more on the needs of the individuals within the group.

The differences between CoMT and community music also need exploring because, at first glance, there seems to be little difference. Both approaches may use performance and Turry explains the distinction between performances undertaken within community music projects and CoMT projects. He states that it is a matter of whether the performance is the goal or whether it is the by-product of the work. A community music project may see a performance as a main goal of the work whilst CoMT projects may consider performances to be more of a by-product with the main aim being a sense of positive growth and development for the community (and the individual).⁴⁷ Ansdell considers there to be a continuum between the two fields and offered this diagram⁴⁸ for clarification:



⁴⁷Alan Turry, 'Performance and Product. Clinical Implications for the Music Therapist,' www.musictherapyworld.net (18.3.02), p.10 cited in Powell, Harriet, 'A Dream Wedding: From Community Music to Music Therapy with a Community' in *Community Music Therapy*, eds. Mercédès Pavlicevic and Gary Ansdell (London: Jessica Kingsley, 2004), p.179

⁴⁸Ansdell, 'Community Music Therapy and The Winds of Change - A Discussion Paper' (2002), p.120

Wood *et al.* also commented on the differences between community music and the whole field of music therapy but do not offer a clear idea about the differences between these two approaches. They only noted that ‘there are points of tension ideologically between these worlds. Not only is there a level of tacit mistrust, but also there are challenges from both sides.’⁴⁹ Whilst these tensions may centre around the different attitudes towards performance it needs to be noted that there may be practical challenges such as a clash of job opportunities due to financial shortages and a disparity of trainings and formal recognition. If an institute can afford only one type of musical input for its clients then the community musicians will be fighting the music therapists for work. The music therapists might aim to reassure the employers that State Registration can guarantee that the work will be undertaken under the code of practice, that the practitioner is accountable to the Health Professions Council⁵⁰ and will receive supervision and other Continuing Professional Development training. Whilst the community musicians may not be able to demonstrate such formal validation, they might offer work which seems to be very similar to that of the music therapist at a cheaper rate. Purchasers are looking at cost effective alternatives and may believe that community music projects may better serve their clients.

Verney and Ansdell explained their concerns that music therapists can be or appear to be anti-community music, regarding it as a poor cousin without formal training.⁵¹ However, as they point out, consensus model music therapists may actually be in a more vulnerable position than community musicians because they only work within very small and specialist areas and have not been flexible enough to explore new approaches to work. Thus traditional music therapy may be forcing itself out of the market by only offering a narrow style of service.

Ansdell asked ‘Can a Community Music Therapy model help bring about a more fruitful match between what musicians are best equipped to give, and what society in the coming

⁴⁹Wood, Stuart, Verney, Rachel, and Atkinson, Jessica, ‘From Therapy to Community: Making Music in Neurological Rehabilitation,’ in *Community Music Therapy*, eds. Mercédès Pavlicevic and Gary Ansdell (London: Jessica Kingsley, 2004), p.51

⁵⁰The regulatory body for the music therapy profession

⁵¹See Verney, Rachel, and Ansdell, Gary, ‘Changing Musicians, Changing Music Therapists?’ (London: British Society for Music Therapy, 2004)

generation will need from them?’⁵² This indicates that CoMT is moulding its work to accommodate the skills of the therapist with the demands of the community. This flexible attitude may increase its chances of survival in a country where cost effectiveness and accountability are highly valued. But Ansdell is aware that the consensus model is reluctant to offer such a flexible service:

My overall conclusion ... is that whilst Community Music Therapy (as a practice and developing theory) is opening the door of music therapy again (when clinically appropriate), the ‘consensus model’ is still shutting it. Now you can’t open and close a door at the same time without (at best) confusion, or (at worst) injury!⁵³

Criticisms of Community Music Therapy

In return there have been some criticisms of CoMT. For example, there is a perceived lack of clear, ethical boundaries for the CoMT projects. Because CoMT projects offer more flexible therapeutic services it is essential that the clients are fully aware of the process in which they are engaged. Anna Maratos explained that within CoMT projects, therapists may take on a number of different roles such as ‘counselor, co-musician, advocate, project coordinator, supervisor, etc.’⁵⁴ Changing the client-therapist relationship may bring about complications and confusion regarding role boundaries and group dynamics. This raises questions as to how transference and countertransference can be handled within CoMT projects.⁵⁵ Issues of confidentiality may also be compromised within CoMT projects and Maratos considers it necessary to recognise the difficulties surrounding situations which include public performance. For example, care is needed not to exploit musically able clients within performance settings:

How music therapy is publicly portrayed is one concern ... It is essential that music therapists are clear about when they are engaged in the practice of music therapy and

⁵²Ansdell, “Community Music Therapy and The Winds of Change - A Discussion Paper” (2002), p.110

⁵³Ansdell, *Community Music Therapy ‘Big British Balloon’ or Future International Trend?* (2003), pp.11-12

⁵⁴Stige, *Elaborations toward a Notion of Community Music Therapy* (2003), p.436

⁵⁵*Ibid.*, chapter 3. Exploring theories from various advocates of CoMT Stige noted that there is disagreement as to whether psychoanalytically-informed techniques are compatible with CoMT.

when they are engaged in alternate uses of music. This is needed as a protection for clients so that they know what they can expect when receiving music therapy services, and as a protection for the profession of music therapy. Ethical professional practice requires that therapists engage in those practices for which they are trained.⁵⁶

However, Stige and Ansdell have both noticed that the manner in which consensus model music therapy is practised differs from the methods being taught on the approved training courses:

[there is a] mismatch between the ship of practice and the flag of theory in our discipline. Certainly in the UK what the recent Community Music Therapy debate has shown up is that sometimes what music therapists do in practice, and what their training suggests they should do in theory, are two different things.⁵⁷

Proctor recognises that his practice does not match that which is taught in the training courses and asked: 'What would my professional association say about this? Am I doing this for my own pleasure or can I really get away with calling it music therapy ... What am I doing?'⁵⁸ This highlights a view that the APMT is perceived as a reprimanding parental figure. The APMT has established clear structures for the field of music therapy and this may have instigated a perception that it is an organisation which is focussed on issues of accountability and standardisation. This will be explored more fully in Chapters Four and Five.

Proctor reacted with relief when he realised that he was offering projects could be acceptable within the CoMT approach even though they may not seem to come strictly under the terms of the consensus model of music therapy. This raises the question to what extent is there disparity between the training and practice of music therapy. Pavlicevic and Ansdell also questioned the relevance of music therapy knowledge which is taught by validated music therapy training courses:

⁵⁶Aigen, Kenneth, 'Conversations on Creating Community: Performance as Music Therapy in New York City,' in *Community Music Therapy*, eds. Mercédès Pavlicevic and Gary Ansdell (London: Jessica Kingsley, 2004), p.212

⁵⁷Ansdell, *Community Music Therapy 'Big British Balloon' or Future International Trend?* (2003), p.4

⁵⁸Proctor, 'Playing Politics: Community Music Therapy and the Therapeutic Redistribution of Music Capital for Mental Health' (2004), p.220

Music therapy has been quite successful in forging itself as a discipline in the last 40 years. Music therapists have benefited from the well-articulated systematic knowledge that the profession has gathered and promoted. It seems to know what it is and what it does. In these days of demand for 'clinical effectiveness,' who could argue with that? Well, *us* actually ... The danger, we feel, is that newer therapists become inducted into a pre-existing order of what is and is not 'proper' (i.e. ethical) practice, and which theories and practices are 'right' and 'wrong' ... One function of CoMT is, perhaps, to suggest that confidence in the consensus model has been premature.⁵⁹ (*italics in the original*)

Pavlicevic and Ansdell question how appropriate or useful it has been to identify specific standards of practice to be implemented by all music therapists. In this dissertation I shall argue that this form of validation has demonstrated a sense of responsibility to the professionals, employers, clients and the public. I argue that the APMT has sought external validation for the training courses in order to demonstrate high levels of responsibility and trustworthiness. Although these actions could be construed as political moves to improve the image of music therapy and thus the preservation of the profession, I argue that this action does not contradict the prime purpose of music therapy, namely the care of the client.

Proponents of CoMT feel that the professionalisation of music therapy which has occurred throughout the past two decades has restricted the flexible and creative attitude of music therapy. Stige explained that the CoMT offers a broad vision of healing and music and is 'a practice fueled by modern longings for undifferentiated beginnings.'⁶⁰ According to Patey and Darnley-Smith recent CoMT projects mirror the 'enlightened Victorian philanthropists who saw the importance of creating a musical community within the walls of the hospital or asylum.'⁶¹ Although advocates of CoMT seem to suggest that CoMT is a new phenomenon Patey and Darnley-Smith disagree. They suggest that the developments that are occurring within the CoMT projects are very similar to the manner in which music therapy 'has constantly been developed pragmatically by music therapists, addressing issues of culture, community and society together with needs that are personal, individual and private.'⁶² Pavlicevic and Ansdell responded to this criticism by suggesting that it is

⁵⁹Pavlicevic, and Ansdell, 'Introduction, The Ripple Effect' (2004), p.28

⁶⁰Stige, *Elaborations toward a Notion of Community Music Therapy* (2003), p.393

⁶¹Darnley-Smith, and Patey, *Music Therapy* (2003), p.10

⁶²*Ibid.*, pp.10-11

irrelevant 'where CoMT comes from, or whether or not it's "new" in a strictly historical sense. The more interesting question is: why is it a practice and a concept that seems to have found its season *now*. Why are people suddenly interested in talking and writing about it?'⁶³ (italics in the original) Although I believe that this response fails to address the point that CoMT is 'simply a new naming of an old game,'⁶⁴ Pavlicevic and Ansdell offer an interesting point. Why has CoMT arisen as a new concept at the end of the twentieth century?

Why has Community Music Therapy Developed?

music therapy should work closely with the needs of society as well as serve both the individual and societal needs of our clients.⁶⁵

Stige explained that, during the twentieth century, there was an increased awareness of the complexity involved with providing effective, appropriate health care. According to Ruud and Stige it is essential to consider what it meant by the term health because it is possible to see that both consensus model music therapy and CoMT can offer a unique service within health care which is not catered for by traditional biomedical or psychological approaches.

Stige sees health as an 'interaction and activity which humans engage in.'⁶⁶ It is a complex set of issues which effect the body, the person and society. An example of this complexity can be seen with the introduction of Care in the Community in the UK which has necessitated the health care support of medics, social workers, therapists as well as the society into which the service users are being integrated. However, each of the health care professionals has tended to focus on the needs of the individual clients rather than investigate the health of the communities themselves.

⁶³Pavlicevic, and Ansdell, 'Introduction, The Ripple Effect' (2004), p.19

⁶⁴Stige, *Elaborations toward a Notion of Community Music Therapy* (2003), p.392

⁶⁵Ruud, *Music Therapy: Improvisation, Communication, and Culture* (1998), p.3

⁶⁶Stige, *Elaborations toward a Notion of Community Music Therapy* (2003), p.207

Bruscia explained that changes for either the individual or the community impact on each other and that the health of each element will support the growth and health of the other.⁶⁷ It is vital to help both individuals and communities 'increase possibilities for action.'⁶⁸ Stige suggested that the medical and the psychology professions have not addressed the notion of *social illness* which is the idea of the lack of health of a community. He stated that music therapy could play a significant role in this untapped region:

... the health concerns in focus in Community Music Therapy are related to *the quality of the relationships between individuals, groups, and communities*, with the consequence that goals of Community Music Therapy will relate to the development of mutual care and qualifications for participation. This clearly underlines the relevance and importance of *expanding the focus* of health musicking *beyond the client-music-therapist relationships*. The health concern to be worked with may involve relationships between individuals, groups, and communities, as well as between various cultural values, practices, and narrative representations.⁶⁹ (italics in the original)

Stige explained that music is a perfect medium for this type of work because group music improvisation, by its very nature, supports the notion of community.⁷⁰ It has been possible to identify musical activities within different cultures and different centuries that have provided healing experiences for communities and the proponents of CoMT have explored these examples in an attempt to understand the contemporary notions of healing, music and community.⁷¹

Stige stated that, by offering a different treatment model to the biomedical approach, the field of music therapy has differentiated itself from these orthodox treatment methods. Stige continued by suggesting that, at the turn of the twenty-first century, the field of music therapy has reached a point in its development when it is fragmenting.⁷² As such the field of

⁶⁷See Bruscia, *Defining Music Therapy* (1998), chapter 23

⁶⁸Ruud, *Music Therapy: Improvisation, Communication, and Culture* (1998), p.3

⁶⁹Stige, *Elaborations toward a Notion of Community Music Therapy* (2003), p.425

⁷⁰Ibid., p.123

⁷¹See for example, Horden, *Music as Medicine: The History of Music Therapy since Antiquity*, (2000); Gouk, ed. *Musical Healing in Cultural Contexts* (2000); Stige, *Elaborations toward a Notion of Community Music Therapy* (2003)

⁷²It could be argued that there have always been divisions within the field of music therapy.

music therapy has become hyper-differentiated. In other words, the specialist field of music therapy has developed an even more specialist branch. If the fragmentation is taken to extremes there may be 'a field where fragments from several fields and disciplines are reintegrated in new ways.'⁷³ For example, in the UK Ansdell suggests that CoMT could incorporate knowledge and techniques from community music and consensus model music therapy to produce a middle ground within a continuum of work.

According to Stige, it is the changing attitudes towards health and treatments that have instigated this differentiation of music therapy from the medical profession. The fragmentation within the music therapy profession itself has come about because of internal disagreements on how to react to these changing attitudes towards health care. Proponents of CoMT have expressed their concern over the professionalisation of music therapy and this has provided an opportunity to break away from the consensus model.

I suggest that this fragmentation within the field has occurred at a specific moment in the development of music therapy in the UK. The music therapy profession has been described in terms of a life span. At the end of the twentieth century it has been suggested that, in the UK, it has reached early adulthood. It has become mature enough to reach ' "adult status" enshrined in law.'⁷⁴ The proponents of CoMT are not content that music therapy has engaged with the process of professionalisation. Diane Waller suggested that the process of professionalisation is primarily concerned with the self-preservation or intentionally promotion of the field.⁷⁵ CoMT has emerged at this point because of a discontent amongst some music therapists at the way in which the consensus model is developing and professionalising. There is concern that the process of professionalisation will be detrimental to the clients because music therapy is focussing on its own needs rather than on the needs of the client. Therefore, the process of professionalisation neglects to pay full attention to the individual needs of each client.

⁷³Stige, *Elaborations toward a Notion of Community Music Therapy* (2003), p.185

⁷⁴Stewart, 'The State of the UK Music Therapy Profession. Personal qualities, working models, support networks and job satisfaction' (2000), p.26

⁷⁵See Waller, 'Come Back Professor Higgins - Arts Therapists need you! The importance of Clear Communication for Arts Therapists' (2001), p.246

I suggest that, despite the criticisms of the professionalisation of music therapy, CoMT would not have been able to develop without the field of music therapy engaging with the process of professionalisation. Successful and sustainable fragmentation can only occur if the whole structure is stable. Music therapy in the UK has gained stability through the process of professionalisation and this will be explored fully within Chapters Three, Four and Five. I suggest that CoMT has been able to develop *because* of the stability of the consensus model of music therapy. Having gained State Registration the field of music therapy in the UK has gained enough security for CoMT to emerge. Therefore, it is inappropriate for proponents of CoMT to criticise a process from which CoMT has been given the opportunity to develop.

Conclusion

Advocates of CoMT consider that the process of the professionalisation of music therapy has played a large part in stifling the creativity of the work. As Bunt stated, 'any moves to rigid standardisation and over-bureaucratisation [are] so much the antithesis to the creative spirit at the root of our work.'⁷⁶ In this chapter I have explored two debates which have occurred during the period 1999-2005 and which have both explored the issue of the independence of the discipline of music therapy.

Aigen argued that the development of an indigenous theory of music therapy would demonstrate the maturity of the discipline and I suggest that the perception of a mature discipline will have an impact on the perception of the profession because it may demonstrate that it is independent and not subordinate to other professions. Streeter suggested that it is inappropriate to deny the usefulness of theories from other disciplines because much can be gained from employing established techniques. I consider to what extent the development of an indigenous theory is motivated by the needs of the client or by a desire to create a perception of a mature discipline. The latter would promote the needs of music therapy above the needs of the client which is a criticism of the process of professionalisation.

⁷⁶Bunt, Leslie, and Hoskyns, Sarah, 'Endnotes,' in *The Handbook of Music Therapy*, eds. Leslie Bunt and Sarah Hoskyns (Hove: Brunner-Routledge, 2002), p.316

I have questioned the motivation behind the desire to develop an indigenous theory. If the field of music therapy is primarily motivated by a desire to promote itself this may be detrimental to the needs of the client. I suggest that the needs of the client are paramount but that, as a by-product, the image of the profession can also be enhanced. The development of an indigenous theory can support the needs of the client as well as help create the perception of a more fully mature discipline which can help promote an image of a more independent profession.

Many of the proponents of CoMT have argued that the field of music therapy is not compatible with the process of professionalisation. These authors recommend that each music therapy project considers the unique needs of the client above the needs of the profession. I argue that the process of professionalisation does not negate the unique care given to clients and will consider this line of argument throughout each of the following chapters. Before considering the process of professionalisation within the context of the historical developments of music therapy in the UK from 1958-2004 Chapter Two investigates what it means to become a profession from a sociological perspective. I consider the argument that no element of the field of music therapy is fully dependent or fully independent from external influences. The tensions between occupations' desire for autonomy and the pressures from external agencies for transparency and accountability are considered.

I have also suggested that the introduction of CoMT has occurred due to a discontent with the process of professionalisation. Stige describes this as a fragmentation of the field of music and I argue that this has been possible because of the stability that music therapy has gained from engaging with the process of professionalisation. It is because the field has gained stability or maturity that it has been possible for a new branch to emerge. To criticise the professionalisation is to damn the process through which CoMT has been able to develop.

In Chapter Two I continue to explore the compatibility between the needs of the client and the needs of the profession of music therapy. I suggest that the needs of the client are not fully dependent on or fully independent from the needs of the profession.

Chapter Two: **Becoming a Profession**

‘... music therapy is struggling to exert its own identity at a stage of development when perceptions of others are still important [and that] our identity is being co-developed.’

Bruscia, ‘Professional Identity Issues in Music Therapy Education’ (1987)¹

This chapter focusses on some of the sociological theories regarding professions and links these with some theories on the development of the music therapy profession. The process of professionalisation is a complex interlinking between the needs of the professions and the needs of clients and the government. With the growing literature on Community Music Therapy there is a developing interest in the profession of music therapy. This interest has focussed in particular on how the profession might engage with the cultural context in which it exists. Articles on CoMT describe a growing discontent of some aspects of the development of the profession of music therapy with particular reference to the perception of a gradual standardization and politicization of the field.

I focus on the issue of the credibility of the music therapy profession within this chapter. The music therapy profession in the UK is influenced by and influences the public. The music therapy profession has been aware, throughout its development, of the importance of its image and the way in which it is perceived by the public. Perhaps the most pertinent issue here is not what the public perceive the image of the music therapy profession to be but the extent to which the profession has been motivated by the need to produce a credible image. I argue that throughout its development the music therapy profession has focussed on the needs and welfare of the clients. I have argued that the music therapy profession and the image of the music therapy profession may also have benefited from these developments. However, I suggest that any benefits to the music therapy profession are not to the detriment of the clients and may, in fact, also benefit the clients too.

As has already been stated, the professional issues relating to music therapy have not been a popular research topic until recently, when there has been a noticeable growth in the amount of research and articles written on the subject. It is only possible to speculate on the

¹Bruscia, ‘Professional Identity Issues in Music Therapy Education’ (1987), p.26

reason for this increased interest. It may be that the authors of these papers feel that there is a need to understand the history of the profession in order to make more informed decisions about the future. As Hesser stated about music therapy in the USA, 'articulating our identity should be our *top priority* now as an organization ... [u]nderstanding who we are will be vital in making ... decisions,'² and Cheryl Dileo-Maranto wrote that the 'future [for the music therapy profession] will not evolve satisfactorily without deliberate foresight.'³

With the deaths of the pioneering music therapists, Juliette Alvin and Sybil Beresford-Peirce, there may be a sense of urgency in the UK to capture historical data before first-hand accounts are lost. Alternatively there may be a desire to understand the new demands made on music therapists as a result of the introduction of State Registration.

At the time of writing most information on the history of the music therapy profession in the UK has been based on anecdotal comments. Certainly no formal research has explored the history of the profession from a sociological perspective although Martyn Parker-Eames gave a paper at the Seventh World Congress in Spain in which he touched on many issues raised in this dissertation. In order to understand the history of the music therapy profession in the UK from a sociological perspective this chapter will explore some of the main issues raised by sociological studies on professions.

I have already investigated the trait theory which was popular in the 1960s and which has received much criticism. In this chapter I explore more recent sociological studies into professions including Freidson's theory that one of the main goals of the process of professionalisation is autonomy.

I noted that the positivistic studies on professions in general, and the music therapy profession in the UK in particular, are useful to a certain extent but fail to take into consideration the broader picture that constitutes the process of professionalisation. Whilst

²Hesser, Barbara, 'AAMT, Coming of Age,' in *Music Therapy* (Vol. 11 (1): 1992), p.18 (italics in the original)

³Dileo-Maranto, Cheryl, 'Music Therapy: Present and Future Trends,' in *Journal for the International Association for Music for the Handicapped* (Vol. 4 (1): 1988), p.21

this dissertation focuses on the music therapy profession in the UK I offer an overview of the some of the reasons why other organisations or occupations may wish to pursue the perceived status of profession. The issues raised here still resonate within the hierarchy of occupations and professions within the UK and it is into this context which the music therapy profession has evolved.

During the nineteenth century, occupations were attempting to gain professional status in the hope of being able to climb the social ladder and to reach the status of the gentry. Although this preoccupation for status does not seem to be paramount for occupations at the end of the twentieth century, the sociologist Larson does recognise that professionals are still perceived to be of higher status and this would suggest a link with the ambitions of the nineteenth century occupations.

Becoming a Profession: The Desire of Occupations

Gaining recognition as a 'profession' was important to occupations not only because it was associated with traditional gentry status, but also because its traditional connotations of disinterested dedication and learning legitimated the effort to gain protection from competition in the labour market.⁴

Eliot Freidson explained that, during the nineteenth century, middle-class occupations were keen to seek the status of profession because it was perceived to be linked to the status of the gentry. Elliott described the medical, legal and clerical professions as *status professions* because only upper classes had the financial backing to be able to complete the professional training. However, with the changing opportunities in education 'the emergence of a pattern of professional career represented for the middles classes a novel possibility for *gaining status through work*.'⁵ (italics in the original) Elliott described these newly-developing professions as 'occupational professions.'⁶

⁴P. Elliott, *The Sociology of the Professions* (London: 1972), p.14 cited in Friedson, 'The Theory of Professions: State of the Art' (1983), p.24

⁵Larson, *The Rise of Professionalism. A Sociological Analysis* (1977), p.5

⁶Magali Larson stated that the desire for gentry status did not influence the rise of professions in the USA and that the founding of professions here was driven by egalitarian, democratic and competitive belief-systems. Status professions are also been-referred to as full professions and occupational professions as semi-professions. These terms will be used within the dissertation.

In the nineteenth century the relationship between the professions (primarily the medical, legal and clerical professions) and the government was weak. The *laissez-faire* attitude⁷ of the time suited both parties. The government was spared the energy of having to intercede in what was considered a private client-professional relationship and the professions were given autonomy which they valued. Interfering with the professional work of the gentry was also considered distasteful.

However, by the end of the nineteenth century there was a movement towards greater government involvement within the affairs of the professions.⁸ The basic changes in the structure of society such as education, urbanisation and economic growth forced the government to pay more attention to the active role which professions were taking in society.⁹ For example, the introduction of the NHS enabled the government to set certain boundaries on the medical profession whilst allowing the doctors some clinical freedom. A profession that carries out the work of a state system, such as the NHS, means that both parties must 'find ways of accommodating the frustrations and resentments of both sides in the partnership, and to devise organisational strategies for containing conflicting interests.'¹⁰

Prior to the creation of the NHS the relationship between the patient and the medical profession involved minimum third party intervention. The Poor Law Amendment Act of 1834 can be seen as the first act of public responsibility on the part of the government for

⁷Laissez-faire economics is described as an 'approach to economics that asserts the importance of the free, competitive market of individual suppliers and individual purchasers to the efficient production, distribution, and allocation of goods and services as well as to the maximization of individual choice, and emphasizes the need to keep state regulation to a minimum.' See Marshall, Gordon, ed. *Oxford Dictionary of Sociology* (Oxford: Oxford University Press, 1998), pp.358-359

⁸See Etzioni, Amitai, *Modern Organizations* (Englewood Cliffs: Prentice-Hall Foundations of Modern Sociology Series, 1964); Larkin, Gerry, 'State Control and the Health Professions in the United Kingdom: Historical Perspectives,' in *Health Profession and the State in Europe*, eds. Terry Johnson, Gerry Larkin and Mike Saks (London: Routledge, 1995), pp.45-54

⁹See Larson, *The Rise of Professionalism. A Sociological Analysis* (1977), p.6; Also see Rueschemeyer, Dietrich, 'Professional Autonomy and the Social Control of Expertise,' in *The Sociology of the Professions. Lawyers, Doctors and Others*, eds. Robert Dingwall and Philip Lewis (London: Macmillan Press, 1983), p.51

¹⁰Klein, 'The State and the Profession: the Politics of the Double Bed,' in *British Medical Journal*, (3.10.1990), p.700 cited in Donald Light, 'Countervailing powers: a framework for professions in transition,' in *Health Professions and the State in Europe*, eds. Terry Johnson, Gerry Larkin and Mike Saks (London: Routledge, 1995), p.31

the health of individuals, stipulating that each parish should have sick wards to treat the needs of the public when they became ill. The introduction of the National Health Insurance Act in 1911 and the founding of the NHS in 1948 changed the relationship between the medical profession and the government and, although the medical profession was concerned about the amount of control the state might impose on them and restrict their autonomy, it was also acknowledged that there were tangible economic and status benefits. The primary concerns for the profession were the establishment of set salary scales, loss of professional autonomy and the imposition of the role of local government which would determine funding and distribution of medical services. John Carrier and Ian Kendall summarised the issues:

The administrative problem related to the traditional points of conflict between bureaucracy and professionalism and between democracy and professionalism - represented by the doctors' fear of the loss of clinical freedom ... [a] means had to be found to integrate professionals into a governmental bureaucracy without raising professional opposition whilst at the same time making the health care system accountable to the political process.¹¹

However, Carrier and Kendall noted that doctors managed to retain much of the autonomy and clinical freedom they had already enjoyed because they held an extremely powerful argument against intrusion from third parties:

The prestige of the medical profession, the private market for their skills outside the NHS, and indeed an international marketplace for medical expertise, can all provide plausible explanations for this example of professional power and influence.¹²

The laissez-faire attitude of the government in the nineteenth century had allowed professions a good deal of autonomy and it could be perceived that the expectation of autonomy stems from this time. As such, the gradual intrusion from the government, the loss of autonomy and the increase of accountability has been most trying for the full professions that existed in the nineteenth century. The semi-professions that have evolved during the twentieth century have developed in an era of accountability and have therefore not enjoyed

¹¹Carrier, John, and Kendall, Ian, *Health and the National Health Service* (London: Athlone, 1998), pp.71-72

¹²Ibid., pp.76-77. Also see Turner, Bryan, with Samson, Colin, *Medical Power and Social Knowledge*, 2nd edition (London: Sage, 1995), pp.137-138

the privilege of autonomy. However, there is still a perception that professions hold more of an elevated and élite position in society than occupations. Freidson wrote:

Autonomy is the prize sought by virtually all occupational groups, for it represents freedom from direction from others, freedom to perform one's work the way one desires.¹³

Autonomy is not something that a profession can work towards without reference to the context in which it exists. If a profession is working with clients then it must take into consideration the needs of the clients, who will, themselves, have opinions regarding the services they are receiving. I suggest that the amount of autonomy that the music therapy profession in the UK enjoys is based on carefully balanced negotiations with the public which includes both the government and the clients.

Freidson suggested that it is the technical knowledge and skills, only available to fully trained professionals, which are beyond lay scrutiny that can offer a profession the potentially fullest amount of autonomy. He called this the 'autonomy of technique' and wrote:

The profession bases its claim for its position [and autonomy] on the possession of a skill so esoteric or complex that non-members of the profession cannot perform the work safely or satisfactorily and cannot even evaluate the work properly.¹⁴

Freidson identified two important and related issues here. Firstly, he explored the relationship between members and non-members of a profession and suggested that if the professionals have sole possession of technical knowledge, the public are, to a certain extent, at the mercy of their power. Secondly, Freidson noted that the professionals are keen to keep this technical knowledge for themselves in order to retain a position of authority. The use of specialist knowledge as a powerful bargaining tool is a crucial aspect of the process of professionalisation which needs to be explored more fully before turning to the specific issues relating to the music therapy profession in the UK.

¹³Freidson, *Profession of Medicine. A Study of the Sociology of Applied Knowledge* (1970), p.368

¹⁴Ibid., p.45

The Concept of Esoteric or Abstract Knowledge and Concrete Knowledge

According to Freidson there is particular professional knowledge which is only known to members of a profession, in contrast to other professional knowledge which can be accessible to both members and non-members of a profession. Abbott identified these two types as *concrete* knowledge and *abstract* knowledge.

Concrete knowledge is accessible to both trained and untrained individuals. It is the structured information which can be easily understood irrespective of training. Abstract knowledge refers to the esoteric or technical knowledge which can only be understood if the individual has been formally trained. MacDonald also suggested that there needed to be a careful balance between abstract and concrete knowledge:

[Abbott] goes on to develop the significance of the polarity between abstraction and concreteness, and to review the forces that 'push abstraction in professional knowledge towards an equilibrium between extreme abstraction and extreme concreteness.' At either extreme, the profession tends to lose credibility; too great abstraction appears to be mere formalism, too great concreteness is judged to be no more than a craft. At some nicely chosen spot in the middle, the possessor of knowledge and technique can successfully exercise professional judgment.¹⁵

Both Freidson and Abbott believed that 'abstraction enables survival'¹⁶ for a profession because it allows the profession to form an élite group which is seemingly beyond scrutiny from the laity. However, Freidson stated that only technical knowledge ought to be held within the realm of the professionals and that professionals and non-professionals should work together with matters concerning practical and ethical issues. In his view a profession ought to aspire to share as much information as possible with the laity because the latter has a right to understand and to have the ability to make decision about the service given. He wrote:

¹⁵Abbott, *The System of the Professions* (London: University of Chicago Press, 1988), p. 102, cited in MacDonald, *The Sociology of the Professions* (1995), p. 165

¹⁶Abbott, *The System of the Professions* (1988), p. 30, cited in MacDonald, *The Sociology of the Professions* (1995), p. 163

It is my own opinion that the professions' role in a free society should be limited to contributing the technical information men [sic] need to make their own decisions on the basis of their own values.¹⁷

Freidson suggested that the following three questions would help a profession clarify the difference between abstract and concrete knowledge:

1. What areas is expertise absolutely necessary and what not?
2. In those areas where expertise is necessary, does expertise which is demonstrably superior to common opinion actually exist?
3. Where there is expertise, what are its limitations?¹⁸

Stige also recognised the importance of separating off specialist knowledge from what he describes as professional practice and issues regarding the profession. However, he perceived that this is necessary to prevent the research from becoming corrupted by the political issues of the profession. He did not want specialist knowledge to be used as a bargaining tool for the advancement of the profession. In this way it could be seen that Stige's prime concern is to protect abstract knowledge from, rather than use it for, political manipulation.¹⁹

If members of the professions are the only people able to understand the abstract information then they are also the only ones able to dictate who is or is not an expert, what constitutes expert opinion and knowledge, and the boundaries of abstract and concrete knowledge. In the case of music therapy Bruscia stated that music therapists need to be scrupulously honest in asking '[a]re theory, research, and clinical practice consistent with the public roles, titles, responsibilities, and standards that we adopt as a profession?'²⁰

Connie Isenberg-Grzeda offered a related view when she stated:

[there is a] present-day need to affirm our professionalism through the parallel processes of (a) theory building, with an emphasis on identifying the theoretical

¹⁷Freidson, *Profession of Medicine. A Study of the Sociology of Applied Knowledge* (1970), p.382

¹⁸Ibid., p.336

¹⁹See Stige, *Elaborations toward a Notion of Community Music Therapy* (2003), p.221

²⁰Bruscia, *Defining Music Therapy* (1998), p.14

underpinnings that reflect our uniqueness ... and (b) elaborating systems of clinical accountability.²¹

However, advocates of Community Music Therapy appear uncomfortable with the whole concept of music therapists in the role of an authoritarian professional or specialist. Stige's concept of CoMT is based on the view that health and music are shared experiences:

Health as quality of human co-existence and as personal qualification for participation in a community implies that health-related practices such as Community Music Therapy need to be concerned with a participatory approach and a *partnership model*, that is, a model where the role responsibilities between client and therapist are negotiated in each situation, depending upon the problems and resources at hand.²² (italics in the original)

The segregation of specialist knowledge, which can only be fully understood by the professional, seems contrary to the ethos of Community Music Therapy. To summarise, Stige considers it important to keep an element of the field of music therapy separate from the political complexities of the work. He described this as the discipline of music therapy, which is a term also used by Bruscia. Bruscia also believed that the discipline of music therapy could be the most field-independent element of the work. These concepts link with Abbott's description of abstract or esoteric knowledge. However, Stige was clear that the act of separating off technical knowledge from the other aspects of the field of music therapy was not, in itself, a political act, or one which created a useful tool for the advancement of the profession.

The proponents of CoMT are concerned that the political nature of the process of professionalisation contradicts the nature of music therapy. They state that the prime focus should be towards the needs of the clients. This chapter now turns to one specific aspect of music therapy to explore the issue of abstract and concrete knowledge and to consider the politicisation of music therapy.

²¹Isenberg-Grzeda, Connie, 'Music Therapy Assessment: A Reflection of Professional Identity,' in *Journal of Music Therapy*, (Vol. 25 (3): 1988), p.156

²²Stige, *Elaborations toward a Notion of Community Music Therapy* (2003), pp.207-208

Music Therapy Assessment Procedures Help to Support the Needs of the Clients and also Help to Raise the Status of Music Therapy

Larson's view was that a profession that was engaged in the process of professionalisation would learn to recognise and work with the boundaries between itself and related professions and gain a clearer sense of identity by liaising with other professions. An example of this complexity which links the profession, the discipline and the professional practice of music therapy in the UK can be found in Isenberg-Grzeda's comments about one element of the practice of music therapy, namely assessment procedures. She suggested that this aspect of music therapy practice has a direct bearing on the image of the profession and stated that assessment procedures are able to enhance the 'professional credibility of ... music therapy ... [because an] ... insistence on the specialized capacities of the music therapist reinforces the concept of a unique contribution to the interdisciplinary team [and] ... establishes a specific technology for music therapists.'²³ She also cited Cohen, Everbach and Katz:

... music therapy cannot achieve true professional stature until an assessment system is developed that highlights the uniqueness of music therapy: this statement thus links music therapy assessment to the establishment of music therapy as a credible profession. This author contends that the manner in which we assess patients reflects out professional identity; consequently, analysis of current assessment methods and tools can increase our understanding of how music therapists relate to their profession, their clients and the larger professional community.²⁴

This suggests that effective assessment procedures need to be developed prior to considering the state of the image of the profession. Therefore, it suggests that the most important task is to create effective assessment procedures because clients will benefit from these procedures. If the clients benefit from effective procedures then the public will perceive that music therapy is a positive service and the image of the music therapy profession will improve. In this manner, the image of the music therapy profession has improved due to the effectiveness of technical skills and abstract knowledge.

²³Isenberg-Grzeda, 'Music Therapy Assessment: A Reflection of Professional Identity' (1988), p.166

²⁴G. Cohen, J. Averbach and E. Katz, 'Music therapy assessment of the developmentally disabled client,' in *Journal of Music Therapy* (Vol.15: 1978), pp.88-99, cited in Isenberg-Grzeda, 'Music Therapy Assessment: A Reflection of Professional Identity' (1988), p.157

Gantt also comments on the assessment procedures of arts therapies. Unlike Isenberg-Grzeda, who suggested that the prime beneficiary would be the clients, Gantt seems to focus more on the manner in which assessment procedures could enhance the success of the music therapy profession. Some assessment procedures developed by other professions can also be applied to arts therapies. However, there is a sense that assessment procedures unique to arts therapies might emphasise the independent nature of the arts therapies, highlight the potential services that only these professions can offer and thus offer a reason for employing arts therapists rather than other related professions. Gantt offered five questions:

1. What are we assessing that other related fields are not or cannot?
2. What can we devise that would be a creditable addition to the battery of existing psychological and psychiatric tests?
3. Are there generic assessments that could be applied to any population or setting?
4. Are we able to demonstrate that we have reliable and valid instruments?
5. Do our assessments mean anything to others besides those of us in the particular discipline?²⁵

By considering these questions, the music therapy profession can gain a clearer picture of the theories and practices unique to itself. Questions one, two and four emphasise that the music therapy field might feel pressured into finding a new, specialist approach to assessment procedures. Larson stated that a profession may survive more effectively if it has monopolised a market. Gantt seems to suggest that, through the development of a specialist assessment procedure, the arts therapies might manage to monopolise an area of work. None of these questions mention the needs of the clients and I question the extent to which Gantt is motivated by the promotion of the profession or the discipline rather than the needs of the clients.

Gantt's third question hints at the concept of standardisation for music therapy assessment procedures. I have already noted the concerns within the music therapy profession regarding standardisation which could neglect the unique needs of each client. Finally, the last question considers how a profession can demonstrate the effectiveness of a specialist procedure whilst retaining an air of professional mystique. This links back to the issue of how abstract

²⁵Gantt, Linda, 'Assessments in the Creative Arts Therapies: Learning from Each Other' *Music Therapy Perspectives* (Vol:18: 2000), p.42, cited in Bunt and Hoskyns, eds. *The Handbook of Music Therapy* (2002), p.251

knowledge can be used by a profession as a power tool to ensure it can monopolise a market.

Having taken the example of assessment procedures I suggest that research or lines of questioning that neglect the needs of the client could become motivated by the needs of the profession or discipline. However, I argue that the development of effective music therapy techniques can benefit the clients and also enhance the image of the profession. As Isenberg-Grzeda stated, 'consequently, analysis of current assessment methods and tools can increase our understanding of how music therapists relate to their profession, their clients and the larger professional community.'²⁶

Qualified Music Therapists and the Laity - Sharing Knowledge - Enjoying Altruism

Gary Ansdell highlighted the changing relationship between the therapist and the service-user in the music therapy profession and noted that there was a definite movement towards a partnership between the two parties. He divided the history of the music therapy profession into four stages. During the first period (1890-1940) patients tended to be passive recipients of musical activity, whether it be a 'medical' intervention or a 'recreational' activity. During the second stage (1940s-1970s) the relationship between the therapist and the client became more reciprocal. Ansdell offered five points to clarify the style of work at this time:

- Moving from playing *to* people to playing *with* them (from 'receptive' to 'participatory' work)
- The use of improvisation to allow spontaneous *co-musicking*
- A focus on the *interpersonal relationship* within the musical, and the modelling of the work on other therapies
- Increasing concentration on *individual* work with patients
- Alliance with medical and therapeutic theory as explanatory and legitimating devices.²⁷ (italics in the original)

²⁶G. Cohen, J. Averbach and E. Katz, 'Music therapy assessment of the developmentally disabled client,' in *Journal of Music Therapy* (Vol.15: 1978), pp.88-99, cited in Isenberg-Grzeda, 'Music Therapy Assessment: A Reflection of Professional Identity' (1988), p.157

²⁷Ansdell, 'Community Music Therapy and the Winds of Change - A-Discussion Paper' (2003), p.114

In the UK the emphasis within the vast majority of music therapy work is on musical improvisation which is seen as a shared partnership. Although a therapist may possess technical knowledge on theories of therapy, the therapeutic relationship is often based on the premise that the therapist is present, not as an expert in the client's needs, but as a supportive professional. This issue may not fundamentally change the theory of abstract and concrete knowledge as set out by Abbott, but it does touch on Freidson's view that the client ought to be given as much knowledge as possible within the professional relationship in order to make his or her own decisions.

Ansdell offered a historical view of music therapy in the UK to help demonstrate the evolution towards CoMT. He explained that, although there has been a tendency within the profession to establish a therapist/client relationship built upon the notion that the therapist held the theoretical, abstract knowledge and the client relied on the therapist's expertise, the introduction of CoMT has brought about a new attitude towards the client/therapist relationship in which both parties participate as equals. However, Jane Edwards writes in support of the consensus model of music therapy²⁸ and believes that Community Music Therapists are insinuating that the traditional style of client/therapist relationship is not respectful of the client. It would appear that CoMT is most concerned that the consensus model has been attempting to create an attitude of professionalism which may undermine the attitude of a supportive therapeutic relationship.

Light offers a more cynical view of the self-promotion of professions. If clients are not able to understand fully the work of a profession they 'have little choice but to grant autonomy in return for promises of quality and altruism and hope for the best.'²⁹ The clients hope that professions will remain objective and altruistic when offering their service. Studies have shown that patients rate the ability to trust a doctor to work in an altruistic manner above the need to assess the quality of the treatment being provided.³⁰ However, Walby and

²⁸See Edwards, online *Voices: A World Forum for Music Therapy* (6.8.02) see the website, http://www.voices.no/discussions/discm4_02.html [part of an online discussion in an electronic journal on a website]

²⁹Light, 'Countervailing powers - a framework for professions in transition' (1995), p.29

³⁰Studies by Illman (*Guardian*, 29.9.1991), and Lupton *et al.*, 'Caveat emptor or blissful ignorance? Patients and the consumer is the ethos,' in *Social Science and Medicine* (Vol. 33-(5): 1991), pp.559-568, cited in Walby, Sylvia, and Greenwell, June, with Mackay, Lesley, and Soothill, Keith,

Greenwell suggested that the commitment to the profession's altruism can be self-serving for both parties. For example, the lay public are content to perceive the trustworthiness of the altruistic doctor in order to feel confident in the skills of the profession, and this in turn helps the profession and professionals to gain more work. Thus altruism can be seen as useful for both the service-users and the professions. However, if a profession is focussed on its own 'interests or prestige, rather than patient well-being, then the value of professional autonomy is questionable.'³¹

Walby and Greenwell suggested that professions tend to emphasise the complex and esoteric nature of their specialist knowledge 'as a form of self-serving mystification, more rhetoric than reality'³² and Bernard Shaw wrote that 'all professions are conspiracies against the laity.'³³ However, Schön suggested that 'professional expertise, when ... exposed to careful scrutiny, dissolves into empty claims'³⁴ Larson wrote:

The singular characteristic of professional power is ... that the profession has the exclusive privilege of defining *both* the content of its knowledge and the legitimate conditions of access to it, *while the unequal distribution of knowledge protects and enhances this power.*³⁵ (italics in the original)

A profession wants to appear trustworthy to the outside world and, at the same time, retain autonomy and authority over its most prized possession, its abstract knowledge. In order to achieve this the profession needs to be carefully balancing a number of different power struggles simultaneously. Hugman explains that these power struggles are within and between members of a profession, between those controlling resources and those who practice the profession, between the profession and the service-users and between the

Medicine and Nursing, Professions in a Changing Health Service (London: Sage, 1994), p.7

³¹Walby, and Greenwell, *Medicine and Nursing, Professions in a Changing Health Service* (1994), p.46

³²Ibid., p.60

³³Shaw, Bernard, *The Doctor's Dilemma*, in *The Complete Bernard Shaw Plays* (London: Paul Hamlyn, 1965), p.515

³⁴Schön, Donald A., *The Reflective Practitioner. How Professionals Think in Action* (London: Arena, 1995), p.288

³⁵Larson, *The Rise of Professionalism. A Sociological Analysis* (1977), p.48

profession and third parties such as the government, society, communities, institutions and employers.³⁶

Proponents of CoMT are concerned that the music therapy profession has engaged in the process of professionalisation in order to secure a successful future for the profession. I have noted the cynical views on altruism and the abusive use of abstract knowledge for power and control. Advocates of CoMT suggest that, if the main focus of the music therapy profession is the welfare of its clients, it would not engage in the process. However, I have also cited Isenberg-Grzeda's view that effective assessment procedures primarily benefit the clients although, as a by-product of this process the profession does also benefit. I also cited Ansdell's historical overview of the development of the music therapy profession which highlights the growing trend towards a client/therapist partnership. Again this emphasises that the prime concern is for the care of the clients. None of the archival material from the APMT or the BSMT, nor any of the other literature read on the development of the music therapy profession in the UK contains any statement suggesting that the needs of the profession comes above the needs of the clients. The APMT has engaged in negotiations to enhance the pay and conditions of the music therapists. However, these negotiations have not been conducted to the detriment of the clients. I also argue that the improvement of the pay and conditions of the music therapists can be seen to have a positive impact on music therapy work, which may benefit the clients.

The Importance of Image

In the nineteenth century and at the beginning of the twentieth century there was a sense of great confidence in the professions. For example, the advances in scientific evidence helped the medical profession gain higher status and the growing confidence of society and the government. By ensuring that it dealt with the classification of diseases within hospital and laboratory environments the medical profession was ensuring its position of authority. However, as Schön noted, particularly during the second half of the twentieth century, the attitude towards the authority of the professions changed. He wrote that '[i]ncreasingly ...

³⁶See Hugman, Richard, *Power in Caring Professions* (Basingstoke: MacMillan Press, 1991), p.5

[society has] become aware of ... complexity, uncertainty, instability, uniqueness, and value-conflict.³⁷

More recently there have been changing perceptions in the status of professions which has originated from a growing crisis in confidence by the public towards the ability of professions to produce what they claim. There have been a number of cases reported which have highlighted unethical practice, practice for financial gain and instability of prescribed drugs which has been instrumental in changing the public's attitude towards the medical profession. Freidson listed four possible views that society has regarding professions. To summarise:

- Professionals are 'experts' exercising power over 'state policy and the personal affairs of individuals.'
- Professionals create artificial dependence on services and controlling the way people perceive their problems and the solutions to them.
- Professionals do not have power - they only administer services.
- Professionals are losing authority 'due to increasing public scepticism, consumer activism and sophistication and decreasing public respect.'³⁸

These opinions are not static but are influenced by changing relationships between professions, service-users and other third parties and professions have had to reassess their position in a society which no longer accepts professional authority unquestioningly.³⁹ By the time the Association of Professional Music Therapists was founded in 1976 public confidence in professions in the UK was waning and there was a general movement towards client choice. Clients wanted to have as much information about the services on offer in order to make as informed choice as possible. The music therapy profession in the UK was having to evolve within this social context and Helen Odell explained to the members of the APMT the importance of creating a corporate image for the organisation:

This may seem a hard priority to some people, and you may be thinking 'what relevance has this to our clinical work?' I can assure you that in the long run, our

³⁷Schön, *The Reflective Practitioner. How Professionals Think in Action* (1991), p.39

³⁸See Freidson, *Professionalism Reborn. Theory, Prophecy and Policy* (1994), pp.30-33

³⁹See Schön, *The Reflective Practitioner. How Professionals Think in Action* (1991), pp.292-299

work will benefit from a better presentation, communication particularly in establishing new jobs and obtaining resources.⁴⁰

Odell was highlighting the connection between the improvement of a professional image and the benefits this might offer the clients themselves. There has been a recognition that the music therapy profession in the UK has needed to plan its development carefully in order to gain respect from the public and other professions. One way in which to improve the image of field of music therapy has been to increase communication between professions. David Aldridge suggested that it would be profitable for all professions engaged in multi-disciplinary teamwork to collaborate with shared education programmes which would have an impact on the credibility of the music therapy profession.⁴¹ Byung-Chuel Choi conducted a study to discover what patients and professionals think about the music therapy service within psychiatric hospitals in the USA. The results demonstrated that most psychiatrists are unconvinced by the service offered, and even the patients who received music therapy were not entirely enthusiastic.⁴²

Cheryl Dileo-Maranto was clear that the 'future [of the music therapy profession] will not evolve satisfactorily without deliberate foresight'⁴³ and Carol Steinhaus and Linda Wright-Bower also reflected on the need to market music therapy when they wrote:

[music therapists] noted the discrepancies or difficulties encountered in presenting their point of view to administrators because of the administrators' focus elsewhere (Steinhaus, 1994) ... music therapists must learn to speak the administrators' vocabulary, adapt to their concerns, and focus on issues which meet the administrators' needs ... they must listen well and perhaps do some research to determine what concerns and topics are being addressed by the institution.⁴⁴

⁴⁰APMT AGM minutes (18.1.1986), p.3

⁴¹See Aldridge, David, 'Of Ethics and Education: Strategies for Curriculum Development,' e-book on *Info-Cd ROM IV Music Therapy World in A Comprehensive Guide to Music Therapy: Theory, clinical practice, research and training*, Tony Wigram, Inge Nygaard Pedersen and Lars Ole Bonde (London: Jessica Kingsley, 2002)

⁴²Choi, Brung-Chuel, 'Professional and Patient Attitudes about the Relevance of Music Therapy as a Treatment Modality in NAMT Approved Psychiatric Hospitals.' in *Journal of Music Therapy* (Vol. 34 (4): 1997), pp.277-292

⁴³Dileo-Maranto, 'Music Therapy: Present and Future Trends' (1988), p.21

⁴⁴Steinhaus, Carol S., and Wright-Bower, Linda-M., 'A Conceptual Framework for Marketing Music Therapy to Healthcare Administrators,' in *Music Therapy Perspectives* (Vol. 13: 1995), p.84

I have already cited Ansdell's concern regarding the possibility of translating music therapy work into verbal language. Steinhaus and Wright-Bower offer a pragmatic view which recognises the need to attempt to communicate the relevance of music therapy to the laity. Bruscia wrote about the inter-connectedness between the discipline and the profession and suggested that confidence in the identity of the discipline will be beneficial for the profession:

It is the writer's [Bruscia] opinion that our identity and status as a profession can only grow when music therapists are fully knowledgeable of and highly skilled in their discipline. The assumption is that when music therapists have such breadth and depth they address more significant clinical problems, they work more effectively, they have greater confidence in their discipline, they represent the profession more lucidly, they demonstrate the powers of music therapy more vividly, they gain better positions in the marketplace, and they earn better salaries. Music therapists will not be *given* higher status by accepting the job specifications of employers, legislators, and regulatory bodies (many of which are financially motivated), they must *earn* higher status by demonstrating their clinical expertise and effectiveness.⁴⁵ (emphasis in the original)

Developing the Profession of Music Therapy around the World

Music therapy organisations from around the world have to cope with issues such as lack of acceptance from other professionals, lack of formal government recognition and financial and employment restrictions. Comments made by music therapists from thirty-eight countries in the early 1990s⁴⁶ tell stories of exciting and encouraging growth as well as difficult struggles in the history of the discipline and the profession of music therapy. Many of the contributions highlighted the unique cultural, economic and political situations of each country and the impact these have had on the development of music therapy. For example, in the early 1990s music therapists in China were having to contend with strict policies, licensing regulations and training ordered by the government. There was no professional association within China at that time⁴⁷ and the desire by the government to have strict control over the activities of the music therapists is clear. In comparison the Association of

⁴⁵Bruscia, 'Professional Identity Issues in Music Therapy Education' (1987), p.27

⁴⁶See Dileo-Maranto, Cheryl, eds. *Music Therapy: International Perspectives* (1993)

⁴⁷See Zhang, Hong-Yi, and Miao, Hong-Shi, 'Music Therapy in China' in *Music Therapy: International Perspectives*, ed. Cheryl Dileo-Maranto (Pipersville: Jeffrey Books, 1993), pp.157-174

Professional Music Therapists (APMT) in the UK has played the role in negotiating terms and conditions with the government and has been able to support the needs of music therapists.

Those writing on the situation in South America make it plain that, due to the vast geographical region, a large array of associations have been established which has possibly caused greater diversity than was useful. Writing about the situation in Brazil, Lia Rejane, Mendes Barcellos and Marco Antonio Carvalho Santo explained:

... currently there is a movement to create an organization which can provide unification. The aim of this organization would not be the standardization of music therapy practice, nor the establishment of education and training standards, as this would be inappropriate ... [i]nstead, its aim would be to bring music therapists together to create a larger bargaining unit in national issues, such as the regulation of music therapy in the country.⁴⁸

Again, the situation in Brazil differs from that in the UK. The APMT in the UK has been actively negotiating with the government as well as involved in the developments of education and training standards. However, the APMT considers it inappropriate to impose any form of standardisation on music therapy practice. The issue of standardization will be explored in Chapter Four as it has been described as part of the process of professionalisation.

Writing in early 1990s many of the contributors state that formal recognition of the field of music therapy by the government or the state would significantly increase possibilities for job prospects.⁴⁹ Di Franco and Perilli described the situation in Italy as 'a phase [between]

⁴⁸Rejane, Lia, Barcellos, Mendes, and Santo, Marco Antonio Carvalho, 'Music Therapy in Brazil' in *Music Therapy: International Perspectives*, ed. Cheryl Dileo-Maranto (Pipersville: Jeffrey Books, 1993), p.104

⁴⁹See, for example, Di Franco, Gianluigi, and Perilli, Gabriella Giordanella, 'Music Therapy in Italy,' in *Music Therapy: International Perspectives*, ed. Cheryl Dileo-Maranto, (Pipersville: Jeffrey Books, 1993), pp.321-340; Konta, Ildiko, and Varga, Katalin Urban, 'Music Therapy in Hungary' in *Music Therapy: International Perspectives*, ed. Cheryl Dileo-Maranto (Pipersville: Jeffrey Books, 1993), pp.263-278; Lecourt, Edith, 'Music Therapy in France' in *Music Therapy: International Perspectives*, ed. Cheryl Dileo-Maranto (Pipersville: Jeffrey Books, 1993), pp.221-238; Lehtonen, Kimmo, 'Music Therapy in Finland' in *Music Therapy: International Perspectives*, ed. Cheryl Dileo-Maranto (Pipersville: Jeffrey Books, 1993), pp.211-220; De Backer, Jos, and Peuskens, Jos, 'Music Therapy in Belgium' in *Music Therapy: International Perspectives*, ed. Cheryl-Dileo-Maranto (Pipersville: Jeffrey Books, 1993), pp.89-102; Wagner, Gabriella, 'Music Therapy in Argentina' in *Music Therapy:*

“pioneering effort” and “official recognition and acceptance.”⁵⁰ They state that a ‘stronger influence in negotiations with the Italian government for recognition of music therapy ... requires a great deal of effort’⁵¹ and seem hopeful that internal disputes will not distract the movement towards formal recognition.

Graciela Sandbank and Chava Sekeles suggested that music therapy in Israel had been nurtured with clear forethought:

There is a growing interest in music therapy, both in governmental circles and within the Israeli general public. From the very beginnings of music therapy in this country, special care was taken to first establish and then demonstrate its beneficial effects, and only then to apply for official recognition. In fact this tactic led to a gradual organic development which served to enhance the public trust in the profession. These factors ... provide an optimistic prognosis for its future.⁵²

Sandbank and Sekeles explicitly offer a link between official recognition and public trust, which sociologists have stressed are important elements in the process of professionalisation. Regula Utzinger, Martin Schuz, Janine Matthys and Fritz Hegi, commenting on the state of music therapy in Switzerland, touched on the issue of professional autonomy as a desirable attribute for a profession. Their comments link with the debate between Kenneth Aigen and Elaine Streeter on the nature of field-independent music therapy. They wrote:

At the present, the main goal of the Association is to procure recognition of the discipline and subsequently the profession. It is hoped that music therapy will acquire its own autonomous and unique identity independent of the rules and regulations of other therapies.⁵³

International Perspectives, ed. Cheryl Dileo-Maranto (Pipersville: Jeffrey Books, 1993), pp.5-34;
Nishihata, Harry K, ‘Music Therapy in Japan’ in *Music Therapy: International Perspectives*, ed. Cheryl Dileo-Maranto (Pipersville: Jeffrey Books, 1993), pp.341-354

⁵⁰Di Franco, and Giordanella Perilli, ‘Music Therapy in Italy’ (1993), p.324

⁵¹Ibid., p.337

⁵²Sandbank, Graciela, and Sekeles, Chava, ‘Music Therapy in Israel,’ in *Music Therapy: International Perspectives*, ed. Cheryl Dileo-Maranto (Pipersville: Jeffrey Books, 1993), pp.317-318

⁵³Utzinger, Regula, Schuz, Martin, Matthys, Janine, and Hegi, Fritz, ‘Music Therapy in Switzerland,’ in *Music Therapy: International Perspectives*, ed. Cheryl Dileo-Maranto (Pipersville: Jeffrey Books, 1993), p.562

The overall impression gained from an overview of the music therapy profession in thirty-eight countries worldwide is the belief that formal acceptance and recognition of the discipline and profession of music therapy will help to support the development of the field. This may seem to be an obvious statement but it demonstrates the dependence that the field of music therapy feels it has on the perceptions of the laity. As Kenneth Bruscia wrote:

... music therapy is struggling to exert its own identity at a stage of development when perceptions of others are still important [and that] our identity is being co-developed.⁵⁴

One specific area which, at first glance, would seem to fit neatly into a more field-independent realm of music therapy is research. However, it soon becomes clear that the type, amount and quality of literature and research produced also seems to have a direct impact on the credibility of the profession.⁵⁵ Jacqueline Robarts urged music therapists to increase publications on the subject to enhance communication with and between colleagues and employers⁵⁶ and Schneider stated that all activities, including research, undertaken by music therapists have an impact on the interface between the music therapy profession and other professions, employers, colleagues, peers, clients and the public. By the early 1980s the APMT was also realising that there was a greater need for more publications in the UK.⁵⁷

Research: One Approach to Creating a Profession

I suggest that those undertaking research projects are motivated by a combination of a desire to learn more about the theories of music therapy and a desire or need to present an acceptable profession. The balance between these two motivating factors will depend on the

⁵⁴Bruscia, 'Professional Identity Issues in Music Therapy Education' (1987), p.26

⁵⁵See Schneider, Erwin H, 'Professional Literature: Creator of an Image,' in *Journal of Music Therapy* (Vol. 5: March 1968), pp.3-5

⁵⁶See Robarts, Jacqueline, Foreword, in *British Journal of Music Therapy* (Vol. 11 (1): 1997), pp.2-3

⁵⁷See for example, APMT AGM minutes (12.11.1983), p.3. Document held within APMT archives. File GR:1. From 1987-1994 the Journal was called the Journal of British Music Therapy and was renamed in 1994, The British Journal of Music Therapy. It is a joint publication between the APMT and the BSMT.

expectations of each research project. Aigen realised that research projects were often attempting to demonstrate the efficacy of music therapy but, in his view, were using inappropriate research methodologies which were not compatible with the nature of music therapy. He wrote:

Though discredited in philosophic circles, the ideals ... [upheld] as models of scientific activity still determine what is considered legitimate science, especially in the softer sciences that are more insecure about their professional status than are fields like physics and chemistry.⁵⁸

Aigen explored which research methodologies were more compatible and had more integrity with the practice of music therapy. He explained that research undertaken to justify the profession and not to enhance knowledge is not only inappropriate, it is also destructive. He wrote:

Somewhere, naturalistic research became equated solely with anecdotal reports which in turn were seen as being arbitrary and invalid. Remediation of this situation will involve a more healthy re-integration of the clinical phenomenon of music therapy process into our research activity.⁵⁹

For Aigen the essence of music therapy is the actual process or experience and, as such, 'focussing research efforts on the production of lawful statements is counter-productive in music therapy, a field where successful clinical efforts are defined by their ability to facilitate freedom, unpredictability and uniqueness.'⁶⁰ He states that music therapy should feel confident in its own theory and approach to create a research methodology and a language which is most suitable to the clinical work itself rather than relying on pre-existent forms of research.

⁵⁸Aigen, Kenneth, *The Roots of Music Therapy: Towards an Indigenous Research Paradigm* (New York: University Microfilms International, 1991), p.45

⁵⁹Ibid., p.148. Also see Amir, Dorit, 'Research in Music Therapy: Quantitative or Qualitative?' in *Nordic Journal of Music Therapy* (Vol. 2 (2): 1993), pp.3-10; Malterud, Kirsti, 'Quantitative research: standards, challenges, and guidelines,' in *The Lancet* (Vol. 358 (9280): 11.8.2001), pp.483-488

⁶⁰Aigen, *The Roots of Music Therapy: Towards an Indigenous Research Paradigm* (1991), p.334

Aigen suggests that it is impossible to translate musical experiences into words and that music therapist researchers need to recognise that translating clinical music into verbal language will alter the essence of the work. He wonders whether it might be possible to treat music as a *bona fide* medium for 'the acquisition and communication of knowledge ... [to] expand the traditional use of verbal language in science to allow it to carry the meaning and expressive value of music.'⁶¹

Whilst Aigen may be exploring the potential of music therapy research from an idealistic perspective Helen Odell-Miller (1995) wrote about the practical needs of the clients and the institution within which a research project is conducted. As she says, 'Research has to be service led in order to obtain funding and owing to this, factors other than just music therapy need to be taken into account, such as moving from clinically based practice and process-orientated research to a relevant research methodology which will look at arts therapies outcomes in general rather than music therapy in particular.'⁶² She is suggesting that, with funding shortages, it might be more important to combine with other arts therapies for survival and support. Odell-Miller stated that enough research has been undertaken to prove the efficacy of music therapy in the field of psychiatry and explained that fund holders, service providers, managers, chief executives and fellow clinicians are asking: 'What are the benefits and outcomes?' and 'How are these the same as, or different to, other relates forms of treatment in a particular service?'⁶³

Waller suggested that music therapists should be asking: 'What are the expectations and needs of society for psychotherapeutic services?' and 'What are the limitations and failures of psychotherapy as perceived by practitioners of the various schools in relation to these expectations and needs?'⁶⁴

⁶¹Aigen, Kenneth, 'Philosophical Enquiry' in *Music Therapy Research - Quantitative and Qualitative Perspectives*, ed. Barbara Wheeler (Phoenixville: Barcelona, 1995), p.480

⁶²Odell-Miller, Helen, 'Investigating the value of music therapy in psychiatry: developing research tools arising from clinical perspectives.' in *Clinical Applications of Music Therapy in Psychiatry*, eds. Tony Wigram and Jos De Backer (London: Jessica Kingsley, 1999), p.124

⁶³Ibid., p.138

⁶⁴Waller, Diane, 'Art therapy in adolescence: a metaphorical view of a profession in progress.' in *Images of Art Therapy. New Developments in Theory and Practice*, eds. Tessa Dalley Caroline Case, Joy Schaverien, Felicity Weir, Diana Halliday, Patricia Nowell Hall, and Diane Waller, (London:

Aigen stated that the development of different research methodologies have come about because of a desperate need to be seen as acceptable. It would be interesting to consider whether the style of research has changed primarily for the benefit of the discipline, the profession and the professionals of music therapy or whether it has been driven primarily by the demands, spoken or unspoken, of external agencies (such as employers).

Wigram is one of the leading proponents for evidence-based research. He noted that qualitative research projects are important but that there needs to be more quantitative models too and stated that there has been an 'overbalance into qualitative paradigm. This is a good paradigm ... [B]ut ... [A]rguments that qualitative research is more appropriate for music therapy are not tenable.'⁶⁵ Wigram offered a clear view of how the music therapy profession might feel able to engage with evidence-based research.⁶⁶ He explains that the lack of standardisation, evaluation tools and research techniques has weakened the field of music therapy, and that this has been particularly difficult when purchasers are demanding more evidence of cost and clinical effectiveness. I shall consider these issues again in Chapter Five.

The Professions, the Clients, the Government - Everyone Helps to Create a Profession

One does not attempt to determine what profession is in an absolute sense so much as how people in society determine who is a professional and who is not, how they 'make' or 'accomplish' professions by their activities, and what the consequences are for the way in which they see themselves perform their work.⁶⁷

The music therapy profession has had to relate, not only to the perceptions of the clients but also the perceptions of other parties such as carers, employers, colleagues and other

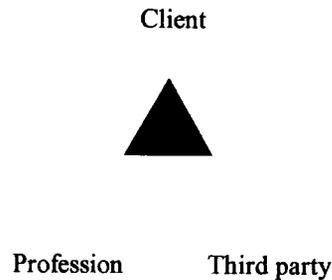
Routledge, 1987), p.190

⁶⁵Wigram, Tony, 'The UK and a European perspective,' in *British Journal of Music Therapy*, (Vol. 17 (2): 2003), p.64

⁶⁶Wigram, Tony, 'Indications in Music Therapy: evidence from assessment that can identify the expectations of music therapy as a treatment for Autistic Spectrum Disorder (ASD); meeting the challenge of Evidence Based Practice,' in *British Journal of Music Therapy* (Vol. 16 (1): 2002), pp.11-28. Also see Ansdell, Gary, Pavlicevic, Mercédès, and Proctor, Simon, *Presenting the Evidence: A Guide for Music Therapists Responding to the Demands of Clinical Effectiveness and Evidence-Based Practice* (London: Research Department, Nordoff-Robbins Music Therapy Centre, 2004)

⁶⁷Friedson, 'The Theory of Professions: State of the Art' (1983), p.27

professional associations and agencies such as the Council of Professions Supplementary to Medicine, the government and the Privy Council. The sociologists Terence Johnson and Richard Hugman divided the parties into three which offered a triangular relationship between the profession, the state and the clients. Expressed as a triangular relationship it is possible to see that, at different times and in different situations, these relationships change, causing different issues to take precedence. The basic triangular structure of this sociological theory is thus:



Johnson stated it is important to consider how the different relationships that could exist between the profession, the consumer/client and the state, government or any other third party such as an employer might have an impact on each party.⁶⁸ He noted that, at different times in history and at different points in the development of each profession, the relationships between these parties changes. He offered three distinct variations of this triangular relationship:

- **collegiate approach:** In this situation it is the professional or profession that defines the needs of the consumer. For example the music therapy profession might offer a diagnosis and a treatment programme which both the clients and the state have little ability or power to contradict. The members of the profession exercises power of the situation and there is little input from a third party.
- **patronage approach:** The client defines his/her own needs and is paying for the service. This situation occurred more frequently during the nineteenth century when the gentry had the power and the means to control a situation and, although a professional or profession might have some ability to offer advice, on the whole it was the client who retained the control. In this situation there is possibly even less (or even non-existent) input from a third party.

⁶⁸Hereafter referred to as the third party unless specified.

- **mediated approach:** A third party mediates between the producer and the client. This could be the government or it could be an institute or employer.⁶⁹

It is possible to see how these three contrasting scenarios indicate the changing dynamics between these three parties. From the perspective of the music therapy profession in the UK, private practice work will tend to have less 'intrusion' from third parties because it is seen as a private relationship and arrangement between the client and the therapist. Indeed the expectation of confidentiality within the therapeutic relationship will enhance this attitude towards privacy. As such, private work becomes a negotiation between the expertise of the professional and the expectations of the client. The client may choose to disregard the expertise of the music therapist, may have limited financial resources or may decide to find another (perhaps cheaper or more geographically convenient) music therapist (or other professional). This leaves the professional in a vulnerable position. Conversely the client may become vulnerable if s/he feels beholden to the professional expertise. For example, a therapist may insist that the client needs to continue to come to therapy frequently and for an indeterminate length of time. The client has little chance to contradict this advice because, as has already been explained, s/he is not privy to the abstract knowledge that the professional has gained.

At first glance it would seem that the mediated approach offers both parties security and support. Richard Hugman offers a scenario in which the government would act as mediator:⁷⁰

the profession -----the government-----the client
(as mediator)

This situation offers the mediator a powerful position between the profession and the client because it can impose regulations. In the specific case of the government holding the role of mediator, it may be able to impose financial restrictions, restrictions regarding the availability of professional services, demand definitions and accountability. Although this scenario could make the government a powerful player, it would need to take into account

⁶⁹Johnson, Terence, *Professions and Power* (London: Macmillan, 1972), cited in Richard Hugman, *Power in Caring Professions* (Basingstoke: MacMillan Press, 1991), p.3

⁷⁰Hugman, *Power in Caring Professions* (1991), pp.26-27

the complaints of the clients (and the professionals) because these individuals can easily change their vote at the next election.

Hugman describes the relationship between a profession and the third party as a 'corporate power relationship' whilst the relationship of the client to either the profession or the third party is a 'non-corporate relationship.'⁷¹ He states that it is the responsibility of both the professions and the third parties (for example, the government) to be working for the good of the clients and not concentrating on promoting their own needs. In reality Walby and Greenwell wondered how much influence or power the clients have in this triangular situation because, although both the government and the professions might seem to be working for the benefit of the clients, the tensions between the two corporate parties could in fact take the focus away from the client.

This dissertation will investigate the relationship between the music therapy in the UK and the government. Until recently there has been general acceptance by music therapists in the UK that links to the government are a positive experience. However, recent articles on Community Music Therapy have started to question the impact this has had on the field of music therapy.⁷² As the relationship between the APMT and the government has changed I shall consider whether the amount of autonomy for the music therapy profession in the UK has diminished and whether the profession is having to accept a more subordinated existence.

The central point of Freidson's theory of professionalization was the power struggle between professions and third parties, particularly the government. I have already noted that Freidson stated that professions seek autonomy through technical expertise which develops through professional discourse. According to this theory professions are élite groups who are in a constant state of struggle to retain their elevated and autonomous position. They fear that their position is threatened by governmental (and other third parties') interference with particular fear of attempts to enforce accountability upon them. It has already been seen

⁷¹Ibid., pp.26-27

⁷²See for example, Proctor, 'Empowering and Enabling - Music Therapy in Non-medical Mental Health Provision' (2003)

that the medical profession has been concerned about the growing amount of demands placed upon them.

Both Magali Larson and Terry Johnson believe that Freidson naively failed to accept how complicated and interconnected the relationships are between the professions and non-professions. Larson suggested that professions hope to gain autonomy, not only through technical expertise, but also through careful interaction with those outside the profession. By hoping to gain respect and trust within these relationships professions aim to gain privileges such as professional autonomy. She stated that, 'autonomy of technique is inseparable from the privileges on which it is founded and into which it extends.'⁷³ She also wrote:

Professionalization is thus an attempt to translate one order of scarce resources - special knowledge and skills - into another - social and economic rewards. To maintain scarcity implies a tendency to monopoly: monopoly of expertise in the market, monopoly of status in a system of stratification.⁷⁴

To work successfully through the process of professionalisation it is necessary for the professions to listen carefully to the needs and demands of the community, the clients and the society which it serves. Larson's theory is based on the belief that 'market control and social mobility ... are inseparable.'⁷⁵ Market control consists of the monopolisation of a certain product or service to maintain a comfortably superior position. More advanced training helps professions to secure higher pay which in turn provides a perceived higher social standing and both the development of market control and the social mobility of professions help to promote both the actual and perceived status of a profession.

It is possible to apply her theories to the music therapy profession. Firstly, the music therapy profession has gained control of the market by establishing externally validated training courses. This has ensured that only those who have successfully qualified are able to practice as music therapists. In this dissertation I shall explain how this has led on to attaining State

⁷³Larson, *The Rise of Professionalism: A Sociological Analysis* (1977), p.38

⁷⁴*Ibid.*, p.xvii

⁷⁵*Ibid.*, p.xvii

Registration and protection of title which have created a clearer distinction between the music therapy profession and other related professionals (such as community musicians). By securing validated post-graduate courses the music therapy profession has demonstrated a high level of competency which Larson suggests can lead to higher pay, a perception of trustworthiness and higher social standing.

The Professional Image Nobody wants to Own

Larson's theory emphasises the self-promoting and self-serving nature of professions. Diane Waller expressed her concerns when she wrote about the incompatibility between the art therapists' preferred attitude of honesty and integrity and a primary care for the needs of the client and the games and strategies that professions appear to play in order to gain higher status.⁷⁶ Also Penny Rogers wrote that '[u]ncertainty or not-knowing, so essential in our clinical practice, may conflict with our need to show professional solidarity in our presentation to the outside world.'⁷⁷ Similarly Richard Mowbray offered his view on the subject:

Professions seek a monopoly over an area of economic activity supposedly to protect the public from incompetent practitioners but they have in practice tended to become perpetually over-concerned with the establishment of the protection of, and the enhancement of their own social status and economic position.⁷⁸

Larson suggested that professions enter into negotiations with society in order to attain a situation in which the profession may be able to survive. She cited Arthur Stinchcombe who stated that '[o]rganizations ... tend to appear ... at the time when it is precisely possible to found them and when they can function effectively with their new structure.'⁷⁹ A profession will only survive if it has gained approval from clients and other parties. I argue that the

⁷⁶See Waller, 'Come Back Professor Higgins - Arts Therapists need you! The importance of Clear Communication for Arts Therapists' (2001), p.246

⁷⁷Rogers, Penny, 'A Place for Uncertainty,' in *British Journal of Music Therapy* (Vol. 10 (1): 1996), p.3

⁷⁸Mowbray, Richard, *The Case Against Psychotherapy Registration: A conservation Issues for the Human Potential Movement* (London: Trans Marginal Press, 1995), p.33

⁷⁹Larson, *The Rise of Professionalism: A Sociological Analysis* (1977), p.6

music therapy profession has been established in the UK at a time when it has gained this approval and it has therefore been possible for the profession to sustain its existence. During the late twentieth century gaining public trust through demonstrations of accountability have been necessary for professional preservation. Throughout its existence the consensus model of music therapy in the UK has attempted to produce evidence of standards and has sought validation through State Registration to gain recognition and acceptance.

Proponents of Community Music Therapy are concerned that the desire to attain public approval is an element of the process of professionalisation which is not compatible with music therapy. I argue that the music therapy has had to engage with this element of the process of professionalisation as a pragmatic means of preserving the music therapy profession in the UK.

Larson and Freidson both explained that the professions and the government are separate from and yet dependent on each other. Freidson suggested that the relationship between the two parties is founded on a struggle based on the professions' desire for autonomy. Larson stated that this relationship is carefully planned to benefit both parties. She wrote:

... given the new 'objective' basis on which privileges are claimed only the state has the appearance of neutrality necessary to guarantee the 'objectively' superior competence of a category of professionals.⁸⁰

Larson and Freidson also stated that professional training leading to the acquisition of abstract knowledge and standardized qualifications are vital within the process of professionalization. However, Freidson commented that the acquisition of technical knowledge is also dependent on the government because, '[d]espite the apparent independence of the professional providers, these special markets required institutional guarantees, which tied them closely to the state - in particular to a state-controlled system of education and credentialing.'⁸¹ All the music therapy training courses have been validated by higher education institutes and this was essential for the music therapy profession in the

⁸⁰Ibid., p.70

⁸¹Freidson, *Profession of Medicine. A Study of the Sociology of Applied Knowledge* (1970), p.216

UK when it was negotiating with the Council for Professions Supplementary to Medicine and the Privy Council for State Registration.

To summarise, Larson's theories were very closely linked to those of Freidson regarding the importance of abstract knowledge for the survival of professions. However, she stressed the idea that professions need to consider carefully their position in society and their relationships with their clients and third parties. Larson explained that the process of professionalization consisted of the practical application of abstract knowledge, a potential market and an awareness of social, economic and ideological issues.⁸² These are issues which also concerned sociologists such as Terry Johnson, Gerry Larkin, Mike Saks and Donald Light although their theories were based on the concept that professions and government are not two separate parties but are 'different aspects, or profiles of a single social phenomenon in the modern world.'⁸³

Johnson *et al.* turned to the theories of Michel Foucault to understand the complexity of 'governmentality.'⁸⁴ The acceptance of the fact that professions are a section of government negates the view that professions are fighting for autonomy *from* the government. Instead, it allows professions to accept that their advancement due to governmental recognition will also promote governmental developments, hopefully for the good of the public. Hugman stated that the corporate power relationship between profession and the government ought to be exerting pressure on each other for the good of the public. Professions who put their energy into seeking autonomy from the government are not working for the benefit of the public but for their own ends. However:

⁸²See MacDonald, *The Sociology of the Professions*, (1995), p.10 and pp.34-35

⁸³Johnson., 'Governmentality and the Institutionalisation of Expertise,' (1995), p.13

⁸⁴The term 'governmentality' was created by Michel Foucault. His theory is based on the concept of the government and the state existing symbiotically. Therefore, professions and government are interlinked. The growth of knowledge brought about through the professions helps governmentality because the experts hold the knowledge necessary to give power to governmentals. Foucault stated to 'work with a government implies neither subjection nor global acceptance. One can simultaneously work and be restive. I even think that the two go together.' Michel Foucault, 'Est-il donc nécessaire de penser?' in *Liberation*, 30.5.1981, p.21, trans., with an afterword by Thomas Keenan 'Is it really important to think?', in *Philosophy and Social Criticism* (Vol. 9. no.1: Spring, 1982), pp.29-40 cited in Colin Gordon, 'Governmental rationality: An Introduction,' in *The Foucault Effect. Studies in Governmentality with two lecture by and an interview with Michel Foucault*, eds. Graham Burchell, Colin Gordon and Peter Miller (Chicago: The University of Chicago Press, 1991), p.48

Once we follow Foucault in conceptualizing the state as the outcome of these interrelations, then we can begin to look at the issues associated with the institutionalization of expertise in a manner quite other than that imposed on us by the state intervention/professional autonomy couple.⁸⁵

The medical profession provides an excellent example of the issues described and much of the literature reviewed explores the professional and relationship struggles within the Health Service. The NHS has had a complex relationship with successive governments. As Larkin stated:

... in the health field the professionalization of any one occupation must be viewed as part of a wider medico-bureaucratic shaping of the twentieth-century division of labour.⁸⁶

The music therapy profession has made more substantial links with the NHS than with education authorities or with any other organization and this dissertation will spend time exploring the changing governmental policies which have impacted on the NHS. Tony Wigram and Diane Waller worked to establish a firm pay and career structure through the Whitley Council. On the one hand it could be argued that the work of the Association of Professional Music Therapists (APMT) and the British Association of Art Therapy (BAAT) focussed so clearly on these negotiations that there was little energy left to support the work of those arts therapists working in education and social services sectors. On the other hand it could be argued that the arts therapies felt more closely affiliated with medical professions and recognised that the Whitley Council offered one clear pay and career structure which worked throughout the NHS unlike the education sector which did not seem to have a clear single system for pay and conditions.

The work of the APMT and the BAAT has focussed on the needs of the professions. Within the APMT archival material there is very little mention of the needs of music therapy clients. It is possible to suggest that the APMT has been motivated by the promotion of the profession rather than the needs of the clients and that this is contrary to the main clinical

⁸⁵Johnson, 'Governmentality and the Institutionalisation of Expertise' (1995), p.18

⁸⁶Larkin, Gerry, 'State Control and the Health Professions in the United Kingdom: Historical Perspectives,' in *Health Profession and the State in Europe*, eds. Terry Johnson, Gerry Larkin and Mike Saks (London: Routledge, 1995), p.46

values of music therapy. Although the APMT has only focussed on the maintenance and promotion of the profession I would argue that this has not undermined the needs of the clients. However, perhaps the criticisms from the proponents of CoMT regarding the professionalisation of music therapy can act as a safe guard for the APMT against an imbalance between the needs of the profession and the needs of the clients.

Conclusion

I have noted that the concept of professionalisation may seem to some music therapists as incompatible with the ethos of a therapeutic relationship because the profession may be manufacturing an image for self-survival rather than for the integrity of the therapeutic relationship or the needs of the client. Carrier and Kendall wrote:

The growth of contemporary professions has attracted a range of accounts. These extend from an essentially positive perspective identifying the functions and inevitability of professionalisation for industrial societies based upon the essential ethic of service to clients; to a more pejorative perspective which identified the process of professionalisation with social exclusion, the aggregation of status, monopoly power and the mystification of knowledge.⁸⁷

I argue that the process of professionalisation is not detrimental to the clients so long as the music therapy profession retains its core motivation to care for the needs of the client. Some music therapists would prefer to perpetuate an image of an altruistic service with an ideal of advocating the needs of vulnerable clients. In this chapter I have suggested that an altruistic service benefits all parties, including the professionals themselves.

I have considered the idea that all parties are involved in the development of a profession. The government, clients, employers, public and other professions are all involved in creating and sustaining a profession and I argue that it is naive to consider the needs of one party without recognising the implications any development has for the other parties. This links with Bruscia's theory that the discipline and profession 'are unable to be entirely field-independent or field-dependent. Our identity is being co-developed. The identity we give

⁸⁷Carrier, and Kendall, *Health and the NHS* (1998), p.312

ourselves influences and is influenced by the identity given to us by others'⁸⁸ and Edwards argument that 'music therapy is always a socio-political work - in simple terms, what we do with our clients and their families in turn effects our society simply by being part of the warp and weft of the fabric of our community behaviour.'⁸⁹

This dissertation now turns to chronicle the music therapy profession in the UK from 1958 - 2003 whilst continuing to investigate the theories of the process of professionalisation. Questions raised within the introduction and within Chapters One and Two will be addressed throughout these chapters, hopefully at pertinent and appropriate points throughout the history.

⁸⁸Bruscia, 'Professional Identity Issues in Music Therapy Education' (1987), p.26

⁸⁹Edwards, Jane, online *Voices: A World Forum for Music Therapy*, (6.8.02) see the website, http://www.voices.no/discussions/discm4_02.html. [part of an online discussion in an electronic journal on a website]

Chapter Three: The Foundation Years: 1958 - 1976

This chapter will continue to explore the development of the music therapy profession in the UK and consider to what extent the profession has sought external support for the co-creation of this process. I will describe some of the events leading up to the founding of the Society for Music Therapy and Remedial Music¹ in 1958. I will then track the evolution of the music therapy profession from 1958 until 1976 when the Association of Professional Music Therapists was founded and which, according to Darnley-Smith and Patey, heralds a new era for music therapy in the UK.²

According to Larson's theory of the process of professionalisation the initial activities in the life of a profession include the establishment of an organisation. I investigate how music therapy in the UK grew from a number of practising individuals to an organised group and consider the specific issues which concern a professional organisation during its infancy. This chapter will describe how the Society for Music Therapy and Remedial Music engaged with these issues.

I suggest that the introduction of the first music therapy training course created some fundamental changes for music therapy in the UK and that the development of specialist knowledge and the segregation between qualified and non-qualified practitioners were two significant developments. The theories of Freidson and Larson emphasise that the development of specialist knowledge, which is only known to those who have successfully completed the training, is one of the most important element in the process of professionalisation.

The development of an élite group of qualified music therapists suggests a clearly bounded set of professionals which, in turn, could lead to the monopolisation of a specialised market dominated by powerfully knowledgeable practitioners. I note however

¹The Society for Music Therapy and Remedial Music will be abbreviated to 'The Society' throughout this dissertation.

²See Darnley-Smith, and Patey, *Music Therapy* (2003)

that professionals tend not to have complete power over a specialist market because of the demands made by the public, by other professions and by the government. I also argue that the prime motive for the music therapy profession for the acquisition of professional knowledge has been to improve the quality of the work. This has benefited the clients as well as the music therapists and the profession as a whole. I explain that Larson's theory does not consider the benefits of the process of professionalisation for the clients. Her theory only focuses on the benefits for the profession itself. I argue that the music therapy profession has considered the needs of the clients whilst also engaging in the process of professionalisation.

There are a number of recent texts which have explored the reasons for the development of the modern music therapy profession and which touch upon the notion that there is a *right time* for a profession to materialise. Peregrine Horden has described how music has been used throughout history to aid health and healing³ and a complementary text compiled by Penelope Gouk offers a view of how music has been used within different cultures.⁴ Similarly both Leslie Bunt and Juliette Alvin cite examples of the use of music around the world during different centuries to demonstrate the long held belief in the use of music to aid healing.⁵ These texts explain that the concept of music and healing is not a phenomenon simply of the twentieth century, nor limited to the Western world. Perhaps a little cynically, Horden suggested that modern, western music therapy seems to be using the long and prestigious history of music connected with healing to justify its current status and to promote music therapy as a legitimate profession. However, Stige believes that it is vital to acknowledge the global, culturally diverse heritage which the profession of music therapy has inherited in order to move forward with a more holistic approach to the use of music within healing. His view focuses on the development of CoMT and there is a concern amongst the proponents of CoMT that the profession of music therapy during the 1960s through to the beginning of the twenty-first century has neglected certain aspects of its heritage (cultural and historical) in order to establish a different image or to align itself with other professions. I will explore how this has occurred throughout the second half of the

³Horden, *Music as Medicine: The History of Music Therapy since Antiquity* (2000)

⁴Gouk, ed. *Musical Healing in Cultural Contexts* (2000)

⁵See Bunt, *Music Therapy. An Art Beyond Words* (1994) and Alvin, *Music Therapy* (1991)

twentieth century and demonstrate how and why the music therapy profession has engaged with the process of professionalisation.

The Introduction of the Modern Profession of Music Therapy

Cheryl Dileo-Maranto offered a chronology of the development of modern music therapy from an international perspective and cited 1832 as the first documented clinical use of music therapy which occurred in the USA.⁶ It was not until early twentieth century that national societies and training programmes were founded alongside a growing number of publications on the subject. For example, Isa Maud Ilsen founded the National Association for Music in Hospitals in the United States of America in 1926⁷ and in the 1940s the first training courses were instigated⁸ at the same time as the founding of the National Association of Music Therapy (NAMT) in the USA. Davis, Gfeller and Thaut wrote:

The years following the founding of NAMT focused on improving education and clinical training as well as establishing standards and procedures for the certification of music therapists. Professional publications also enhanced the credibility of the young organization ... Perhaps the most important action taken by NAMT during its early years was the establishment of the Registered Music Therapist (RMT) credential.⁹

Other countries were also gaining enthusiasm for the use of music within hospitals. Ruth Bright and Denise Grocke wrote about links between an USA and Australian society named 'The International Society for Musical Therapeutics' established in the early 1920s but, for

⁶See Dileo-Maranto, Cheryl, 'An Historic Chronology of 20th Century International Music Therapy Developments,' in *Music Therapy: International Perspectives*, ed. Cheryl Dileo-Maranto (Pipersville: Jeffrey Books, 1993), pp.707-717. See also William B. Davis, Kate E. Gfeller, Michael H. Thaut, *An Introduction to Music Therapy, Theory and Practice* (Dubuque: Wm. C. Brown, 1992)

⁷See Davis, Gfeller, and Thaut, *An Introduction to Music Therapy, Theory and Practice* (1992)

⁸Michigan State University had the first music therapy curriculum in 1944; University of Kansas held the first full academic course in 1946; other courses to begin in the USA during the 1940s were the Chicago Musical College, College of the Pacific, and Alverno College. These courses were a mix of undergraduate and graduate levels. See Davis, Gfeller., and Thaut, *An Introduction to Music Therapy, Theory and Practice* (1992), and Bunt, *Music Therapy. An Art Beyond Words* (1994)

⁹Davis, Gfeller, and Thaut, *An Introduction to Music Therapy, Theory and Practice* (1992), pp.31-32

some unknown reason, the Australian branch ceased to exist by the early stages of the Second World War.

In the UK one significant organisation existed prior to the founding of the Society of Music Therapy and Remedial Music which was The Guild of St. Cecilia, established in 1891 by Canon Frederick Kill Harford. He gathered together a small women's chorus, a harpist and some violinists to perform to patients from behind a screen (believing that the musicians should remain anonymous).¹⁰ Harford was keen to develop suitable trials to establish the effectiveness of music for people suffering with mental and/or physical disorders. He recognised that, by establishing research into the efficacy of music within the hospital environment, he might be able to prove the therapeutic value of music and enhance the image and develop the work of the Guild. This drive to establish effective research has been continued throughout the decades with music therapists recognising that research increases knowledge and information which, in turn, enhances the credibility of the discipline and profession.

Harford also suggested that an organisation should be established to offer a supportive network to those involved with offering music within hospitals. Furthermore, he explored the possibilities of professional payment, recognising the professional status of these musicians. Despite some positive endorsements by such people as Florence Nightingale and Sir Richard Quain the work of Harford received criticism and, with little money to continue the project, the Guild did not continue. Alvin described this work as 'a premature but interesting experiment in music therapy'¹¹ and Dr. Hunter wrote that 'The St. Cecilia Guild - excellent as their intentions were - worked somewhat fitfully and aimed too high.'¹² It would appear that, although Harford had enormous enthusiasm for the work, the Guild was not supported enough by other parties.

¹⁰See Tyler, Helen, 'The Music Therapy Profession in Modern Britain,' in *Music as Medicine: The History of Music Therapy since Antiquity*, ed. Peregrine Horden (Aldershot: Ashgate, 2000), pp.375-393, and Davis, William, 'Music Therapy in Victorian England,' in *Journal of British Music Therapy* (Vol. 2 (1): 1988), pp.10-16

¹¹Alvin, *Music Therapy* (1991), p.50

¹²*The British Medical Journal* (14.3.1896), p.679 cited in Davis, 'Music Therapy in Victorian England' (1988), p.14

Smaller, less well documented projects were also developing at this time. For example, Dr. Mitchell who worked at Warlingham Park Hospital at the end of the 1940s organised groups of patients to play together and 'the primary object was treatment rather than a high standard of performance.'¹³ Mitchell also established music therapy at the Cane Hill Psychiatric Hospital in 1946 which was continued by Nora Gruhn, his wife, after he died in 1953.¹⁴ Also Mair Brooking, Dr. Zanker and Dr. Glatt and Dr. Dax all employed live and recorded music for patients with mental health issues. The view was that 'patients' reactions to music can be of diagnostic value as they sometimes enable the uncovering of unconscious attitudes.'¹⁵ Meanwhile the Entertainments National Services Association (ENSA) was established to help boost the morale for servicemen and the Council for Music in Hospitals helped to arrange concerts within hospital and community settings.

Certainly the expansion of various therapies in the late 1940s and early 1950s and the use of recreational activities for convalescing soldiers (particularly in the USA) may help to explain the growing interest in different art therapies at this time.¹⁶ Van Deurzen suggested that psychotherapy needed to 'transform what used to be a craft or an art based on moral or religious principles into a scientifically based accountable professional expertise.'¹⁷ Gary Ansdell described the use of music within hospitals during the period 1890-1940:

... mostly non-participatory, music being played *to* patients ... Large hospital communities attempted to mirror the 'outside world,' with recorded music, hospital choirs and bands, performances for patients, or sometimes by patients. These in turn linked hospital music-making with the forms of amateur musicianship in Edwardian

¹³BSMT bulletin, Winter 1967/68, p.18. Document held within BSMT archives.

¹⁴BSMT bulletin, Autumn 1969, p.20

¹⁵BSMT bulletin, Winter 1967/68, p.18

¹⁶See McLeod, John, *An Introduction to Counselling*, 2nd edition (Buckingham: Open University Press, 1998)

¹⁷E. van Deurzen-Smith, 'The Future of Psychotherapy in Europe,' in *International Journal of Psychotherapy*, (Vol.1 (1): 1996), p.17, cited in Michael Barham, 'One man milking a male-goat and another holding a sieve underneath to collect the milk,' in *Arts - Therapies - Communication. On the Way to a Communicative European Arts Therapy*. Vol 1. eds. Line Kossolapow, Sarah Scoble, and Diane Waller (Münster: Lit Verlag, 2001), p.238-239

society (in turn underpinned by an attitude which considered music a benign social force).¹⁸ (*italics in the original*)

Ansdell went on to suggest that the end of the Second World War to the founding of the Society for Music Therapy and Remedial Music (in 1958) was a pivotal point in the development of both the discipline and the profession. He describes this as the second stage within the history of music therapy in the UK. He noted that pioneering music therapists were making connections between 'the prevailing psychological and medical models of the day'¹⁹ and the use of music within therapeutic settings. Helen Tyler points out that the pioneering music therapists at this time were becoming more aware of the potential links that could be made between music-making and psychotherapy techniques.²⁰

One of the links made was between free association²¹ and free improvisation²² which is a much used technique by music therapists in the UK. Both techniques allow spontaneous expression free from expectations and direction and it is hoped, in both instances, this will enable a patient to explore issues without constraints.²³ As Ansdell stated musicians were

¹⁸Ansdell, 'Community Music Therapy and the Winds of Change - A Discussion Paper' (2003), pp.112-113

¹⁹*Ibid.*, p.113

²⁰See Tyler, 'The Music Therapy Profession in Modern Britain' (2000)

²¹Free association was introduced as a psychoanalytic technique by Sigmund Freud and has been thus: '[Freud] developed the technique of *free association* ... Patients were encouraged to report whatever came into their mind, however trivial, irrational, or disturbing it might seem; this became known as the "basic rule" of psychoanalysis.' (*italics in the original*) Brown, Dennis, and Pedder, Jonathan, *Introduction to Psychotherapy. An Outline of Psychodynamic Principles and Practice* (London, Routledge, 1979), p.115

²²Improvisation can be used in a variety of ways within the context of music therapy. Darnley-Smith and Patey describe a continuum of musical approaches from 'free improvisation' (which is not based on a structure or theme), to 'tightly structured music' (which is based on pre-composed music). See Darnley-Smith, and Patey, *Music Therapy*, (2003), p.80. In describing 'free improvisation' Streeter also mentions free association. She wrote: 'My premise is that what we offer in free improvisation is free association within music. When we say to a client "You are free to play whatever you wish, there are no limits as to what you can play and on which instrument you choose to play it," we open the door to free association, not via words but via sounds and musical ideas.' Streeter, Elaine, 'Definition and Use of the Musical Transference Relationship,' in *Clinical Applications of Music Therapy in Psychiatry*, eds. Tony Wigram, and Jos de Backer (London: Jessica Kingsley, 1999), p.88

²³Darnley-Smith and Patey comment on the similarities between free improvisation and free association thus: 'The technique of free improvisation as used by music therapists has direct parallels to free association, as we believe that in improvising the client is presenting a self-portrait in music and that, through the shared musical interaction, a therapeutic relationship can be gradually formed.' Darnley-Smith, and Patey, *Music Therapy* (2003), p.72. See also Ruud, Even, *Music Therapy and its Relationship to Current Treatment Theories* (St. Louis: MMB Music, 1980)



increasingly playing with rather than to patients and this suggests an attempt at offering a shared therapeutic attitude rather than an attempt to entertain the patient.

Tyler and Alvin noted that the musical language in the western world during the twentieth century was encouraging freer tonality and greater exploration of the use of sound. The growing use of avant-garde techniques within other musical contexts enabled music therapists to use free improvisation with more confidence. As Rachel Darnley-Smith stated, '[m]usic therapists work with musical sounds that have not necessarily been crafted into compositions and are at their best raw and spontaneous.'²⁴

The musicians who worked within psychiatric hospitals and had noted the links between their use of free improvisation and the technique of free association being used by psychotherapists 'began to call themselves music therapists, and became the founder members of the Society for Music Therapy and Remedial Music.'²⁵ However, music therapy was not perceived by some people as a viable profession or a credible discipline. Henry Rollins was clear that music therapy should recognise its limited potential and ought not to presume to move into the realm of medical treatment:

Music could only be rated as an ancillary form of treatment, or perhaps as a catalyst, facilitating other therapeutic procedures. Music therapy must still be regarded as an experimental project ... It was difficult to specify when this activity was entertainment or of therapeutic value. Often it was a mixture of the two and to distinguish between them was futile.²⁶

The fact that these musicians were attempting to establish the title 'music therapist' suggests that there was desire to try to create a sense of a specialist therapeutic use of music and to distinguish this style of work from other musical activities held within hospitals. These music therapists were hoping to create a boundary between themselves and other musicians

²⁴Rachel Darnley-Smith, *What do Music Therapists Hear?* unpublished paper presented at the 'Music and the Psyche' Conference, City University, London, (1996), p.34 cited in Tyler, 'The Music Therapy Profession in Modern Britain' (2000), p.386

²⁵Tyler, 'The Music Therapy Profession in Modern Britain' (2000), p.383

²⁶H. Rollins, 'Music in Mental Hospitals,' in *Bulletin of the Society for Music Therapy and Remedial Music* (Vol. 10: Summer 1962) cited in Tyler, 'The Music Therapy Profession in Modern Britain' (2000), pp.383-384

working in related or similar fields. By creating the title of music therapist there was a hope that laity and professionals would begin to recognise the unique service that these 'music therapist musicians' were offering. This desire to demonstrate a unique and separate status has been a feature of music therapy in the UK throughout the decades and will be explored within each chapter.

Some of the early literature shows a great enthusiasm to experiment with the use of music within a large variety of situations. Helen Tyler noted not only the use of music within hospital environments, but also the growth of recreational and educational models of music therapy.²⁷ Paul Nordoff and Clive Robbins and Juliette Alvin had been working within schools and there are accounts of successful music therapy sessions at this time.²⁸ The 'Education (Handicapped Children) Act' of 1970 encouraged a belief that children, who had previously been considered 'ineducable,' were capable of coping with a school environment. Alvin quoted The Department of Science and Education:

... the value of music in the personal development and the social experiences of handicapped children cannot be overrated. It is one of the few subjects, interests or skills which can develop steadily from early childhood into adulthood and so help the adult towards social integration.²⁹

Schools were becoming more receptive to the therapeutic use of music and this was helped by the introduction of the 'Education (Handicapped Children) Act' in 1970. There was also a growing acceptance of psychotherapeutic theories and techniques within psychiatric hospitals and both these developments helped to support the introduction of music therapy. However, before considering the specific developments of music therapy in the UK I will give an overview of the perception of the complementary medicines in contrast to the orthodox or traditional biomedical profession in the UK. This is another important issue

²⁷Tyler, 'The Music Therapy Profession in Modern Britain,' (2000), p.382. Juliette Alvin referred to the different approaches within psychology as 'behavioural, environmental, developmental or social.' Alvin, *Music Therapy* (1991), p.103

²⁸Nordoff, Paul and Robbins, Clive, *Music Therapy in Special Education*, 2nd edition (St. Louis: MMB Music, 1983) and Alvin, *Music Therapy* (1991); Alvin, Juliette, *Music for the Handicapped Child*, 2nd edition (London: Oxford University Press, 1976)

²⁹*Music in Schools*, (Report on special schools in the Department of Science and Education pamphlet: 1969) cited in Alvin, *Music Therapy* (1991), p.113

which has a direct bearing on the professionalisation of music therapy within the UK. Larson pointed out that, if a service is wanted from the public, then a profession will have more chance of success. Furthermore she noted that if 'a profession's ideology fits well with the public's/society's ideology this will serve all concerned well.'³⁰ Horden believed that music therapy has been able to reassert its status as an effective treatment due to the changing perceptions of the public.³¹

The Semi-Professions: A Gradual Acceptance

During the past century physicians in Britain have used their influence to ensure that many new medical occupations - dietitians, physiotherapists, chiropractors, for example - do not pose a serious threat to the dominance of doctors. Doctors have succeeded in obtaining legislation which ensures that professions "supplementary to medicine" may only carry out treatment after prior diagnosis by a doctor, thus subordinating them to the authority of doctors ... Illich (1973) has referred to this process as "occupational imperialism."³²

Doctors have dominated the medical world and, in doing so, have put nurses, midwives, dentists, pharmacists, opticians, paramedics and arts therapists in positions of subordination. Turner suggested that this can be viewed in a patriarchal way because the majority of subordinated jobs are primarily undertaken by women. As such the feminist theory argues that women are being undervalued.³³ David Stewart's survey of the music therapy profession in the UK highlighted that less than 20% of music therapists in the UK in 2000 were male.³⁴ Although this survey offers only a snapshot of the situation at the beginning of the twenty-first century there have always been more female than male music therapists in the UK throughout its history.

³⁰Larson, *The Rise of Professionalism: A Sociological Analysis* (1977), pp.47-48

³¹Horden, 'Musical Solutions: Past and Present in Music Therapy,' in *Music as Medicine: The History of Music Therapy since Antiquity*, ed. Peregrine Horden (Aldershot: Ashgate, 2000), pp.4-40

³²Illich, I., 'The Professions as a Form of Imperialism,' in *New Society* (13.9.1973), pp.633-635, cited in Bilton, Tony, Bonnett, Kevin, Jones, Philip, Stanworth, Michelle, Sheard, Ken, and Webster, Andrew, *Introductory Sociology*, 2nd edition (Basingstoke: Macmillan, 1987), p.484

³³See Turner, Bryan, with Samson, Colin, *Medical Power and Social Knowledge*, 2nd edition (London: Sage, 1995), pp.130-131

³⁴Stewart, 'The State of the UK Music Therapy Profession. Personal qualities, working models, support networks and job satisfaction' (2000)

In 1969 Richard Simpson and Ida Harper Simpson suggested that those who choose to enter semi-professions were not so committed to their work as those who worked within full professions. In particular they noted that women enter these professions as a 'temporary haven before marriage.'³⁵ It can be argued that these ideas are out-dated but there are still concerns regarding the differences between full professions, which continue to be dominated by male workers, and semi-professions, which continue to be dominated by female workers. It has been noted that many music therapists leave the profession and³⁶ Stewart offered a number of suggestions for this exodus:

A tentative hypothesis might be put forward about a move away from the profession at a time when creating a family might be a priority for its predominately female membership. Similarly, a link might be made between a perceived lack of promotion prospects within music therapy and a move away from the profession at an age when the financial demands of family life and professional ambition compete for realisation.³⁷

Many of the semi-professions (including music therapy) working within the health service have focussed on patients with 'low status' needs while 'high status' patients have been serviced by the more prestigious professionals such as doctors, surgeons and consultants. Carrier and Kendall offer the following lists showing the differences between low and high status medical conditions:

HIGH STATUS

physical health problems
 hospital-based
 curative
 curative
 curative
 acute health problems
 life-saving interventions

LOW STATUS

mental health problems
 community-based
 caring
 preventive
 health-promotion
 chronic health problems
 terminal care

³⁵Simpson, Richard L., and Simpson, Ida Harper, 'Women and Bureaucracy in the Semi-professions,' in *The Semi-Professions and Their Organization. Teachers, Nurses, Social Workers*, ed. Amitai Etzioni (New York: Free Press, 1969), p.200

³⁶Wigram noted at the APMT AGM in 1981 that more music therapists were qualified than were actually practising, See APMT AGM minutes (7.11.1981), p.2

³⁷Stewart, 'The State of the UK Music Therapy Profession. Personal qualities, working models, support networks and job satisfaction' (2000), p.22

According to Carrier and Kendall the discrepancies between high and low status are due to the power and influence of the full professions, the fact that providing resources for acute medical conditions is more 'profitable' than for chronically ill patients and the belief that, since this situation has 'always' existed, there is no reason to change. Both the professionals and the patients who are given low status (these services are known as Cinderella services) are in weaker negotiating positions than the high status treatment programmes which employ more powerful, fully-fledged professions.

According to Freidson paramedics have been subordinated by the medical profession because their knowledge originates from medics and so they cannot claim to have sole possession of unique knowledge. He also suggested that, because paramedics tend to assist doctors and do not hold the responsibilities for initial diagnosis, the paramedics need either to be content with their position of subordination or 'find some independent source of legitimacy.'³⁹ This dissertation has already cited Aigen's theory that the music therapy profession ought to aspire to employing only indigenous theories, techniques and knowledge rather than employing knowledge from other disciplines. I have suggested that this would help the music therapy profession to be perceived as a mature, fully-fledged profession which was not subordinated. A Department of Health Circular written in 1977 emphasised the unequal relationship between doctors and therapists with the latter being at the mercy of the doctors referral procedures:

In asking for treatment by a Therapist, the Doctor is clearly asking for the help of another trained professional, and the profession of medicine and the various therapies differ. It follows from this that the therapist has a duty and a consequential right to decline to perform any therapy which his professional training and expertise suggests is actively harmful to the patient. Equally the Doctor who is responsible for the patient has the right to instruct the therapist not to carry out certain forms of treatment which he believes harmful to the patient.⁴⁰

³⁸Carrier and Kendall, *Health and The National Health Service* (1998), p.97

³⁹Freidson, *Professions of Medicine. A Study of the Sociology of Applied Knowledge* (1970), p.67. Also see p.48

⁴⁰Department of Health Circular HC 77 33, *On the relationship between the medical and Remedial Professions*, (September 1977) cited in APMT AGM minutes (24.9.1977), p.7

Whilst Myra Levick explained that arts therapists in the USA 'were never intended to hold positions of authority'⁴¹ Connie Isenberg-Grzeda disagreed and wrote that it would be helpful for music therapists to 'view their role as primary rather than adjunctive ... as relevant and central to the treatment process.'⁴² I agree with Bruscia's view that the music therapy profession is being co-developed. Therefore, the level of authority held by the music therapy profession will depend, not only on what the music therapists themselves perceive to be an appropriate amount of authority, but also on what the public and other professions perceive to be appropriate. The development of the music therapy profession is vulnerable to the decisions or whims of others. I argue that the music therapy profession has been aware of this vulnerability throughout its history and has worked to acknowledge realistically its relations with allied professions. An example of this can be seen in the negotiations conducted to secure a place under the umbrella of the Council of Professions Supplementary to Medicine which will be explored later in this dissertation.

Mike Saks suggested that the orthodox medical professions had been nervous of the development of the alternative and complementary medicines because more patients were becoming interested in exploring them. These professions had also gained more political influence, possibly as a result of the growing public interest.⁴³ Cant and Sharma and Saks stated that there was growing interest in alternative medicines during the 1960s and 1970s because there was general concern that drug trials were not safe and could not be relied upon. There was also a growing concern about the perceived authoritarian attitude of medics and the public wanted to be able to make their own choices regarding treatment procedures. Saks suggested that alternative and complementary medicine (including the art therapies) managed to establish and maintain themselves due to these changing views.⁴⁴

⁴¹Levick, Myra F., 'The Identity of the Creative Arts Therapist: Guided by Ethics,' in *The Arts in Psychotherapy* (Vol. 22 (4): 1995), p.284

⁴²Isenberg-Grzeda, 'Music Therapy Assessment: A Reflection of Professional Identity' (1988), p.168

⁴³See Saks, Mike, 'The Changing Response of the Medical Profession to Alternative Medicine in Britain. A Case of Altruism or Self-Interest?' in *Health Professions and the State in Europe*, eds. Terry Johnson, Gerry Larkin and Mike Saks (London: Routledge, 1995), p.112

⁴⁴See Cant, Sarah, and Sharma, Ursula, eds. *Complementary and Alternative Medicines - Knowledge in Practice* (London: Free Association Publishers, 1996)

Conversely, Horden stated that the growth of technical, positivistic medical knowledge which occurred in the twentieth century has prevented the general public from perceiving complementary and alternative therapies as an effective treatment procedures. He suggests that the public are keen to have access to treatment that can be proven to be effective and this suits the biomedical profession as it helps to ensure a clearer monopoly on medical treatments. Mike Saks wrote:

The British Medical profession is regarded as illustrative of an occupation that has so effected social closure, by securing a privileged position in the health care market ... the medical establishment has generally managed successfully to defend its own professional interest in the face of the challenge posed by outsiders.⁴⁵

Cant and Sharma suggested that there has been a gradual recognition that the medical profession may not possess the only effective method of treatment. These 'cracks' in the power of the medical profession may have enabled the complementary and alternative medical professions to gain some status and power within the medical market. It has already been noted that an organisation will not only emerge but survive if it is founded at the right time:

[both the] organizational capacity at a given time [and] ... certain basic societal variables ... have a positive effect on both the 'motivation to found organizations' and the 'chances of success of new organizational forms.'⁴⁶

I shall now turn to the development of the first organisation for modern music therapy in the UK, namely the Society for Music Therapy and Remedial Music.

⁴⁵Saks, Mike, 'From Quackery to Complementary Medicine: The Shifting Boundaries Between Orthodox and Unorthodox Medical Knowledge,' in *Complementary and Alternative Medicines Knowledge in Practice*, eds. Sarah Cant and Ursula Sharma (London: Free Association Press, 1996), p.28

⁴⁶Arthur Stinchcombe, 'Social Structure and Organizations,' in *Handbook of Organizations*, ed. James G. March (New York, McNally, 1965), p.153, cited in Larson, *The Rise of Professionalism: A Sociological Analysis* (1977), p.6. In this dissertation I suggest that the founding of the Society of Music Therapy and Remedial Music did not instigate the process of professionalisation. Rather, the Society was founded to offer support and disseminate information to members and non-members of the Society.

The Society for Music Therapy and Remedial Music

The Society was founded with the enthusiasm and dedication of Juliette Alvin. The foreword of the latest edition of *Music Therapy*, stated that Juliette Alvin was the 'founder of the music therapy profession in Britain.'⁴⁷ She was a formidable character and the driving force behind the founding of the Society which fits with Diane Waller's opinion that 'pioneers [tend] to be individualists.'⁴⁸ The purpose of the Society was to promote the existence of music therapy, to disseminate information, to act as a forum for interested parties, to share information and to act as a support network for those working within the broad realm of music therapy and remedial music. Those who founded the Society were hoping that music therapy would gain recognition and respect and the forming of an organisation helped to emphasise the growing interest in this discipline. I suggest that the very existence of the organisation enabled these developments to occur. As Richard Hall noted:

... in order to achieve change, *there must be organisation*. Spontaneous demonstrations or collective emotional responses may be sincere and well intended, but longer-lasting movements towards change must come about through the organizational mode.⁴⁹ (italics in the original)

Paul Thompson and David McHugh stated that organisations act as an interface between the individual and the wider society and, as such, have more influence and financial strength than the individuals who make up the membership of the organisation.⁵⁰ More vitally for this thesis Barry Bozeman explained that an organisation is neither wholly private nor totally public and that both parties have a stake in the running of the organisation.⁵¹

⁴⁷Foreword (anon) from Alvin, *Music Therapy* (1991)

⁴⁸Waller, Diane, 'Art therapy in adolescence: a metaphorical view of a profession in progress' (1987), p.198

⁴⁹Hall, Richard H., *Organizations. Structure, Processes, and Outcomes*, 6th edition (Englewood Cliffs: Prentice Hall International Editions, 1996), p.18

⁵⁰See Thompson, Paul, and McHugh, David, *Work Organisations - a Critical Introduction* (Basingstoke: Macmillan, 1990)

⁵¹See Bozeman, Barry, *All Organization are Public: Bridging Public and Private Organizational Theories* (San Francisco: Jossey-Bass Publishers, 1989)

The Society for Music Therapy and Remedial Music had its inaugural meeting on 3rd May 1958 at Overseas House, St. James, London and was attended by musician, doctors, educationalists, teachers, therapists and students. Several societies had sent representatives, including the National Association for Mental Health. A Constitution which had been drafted by the Committee was adopted unanimously by those present and became the official Constitution.⁵²

The Society produced bulletins which offered information on a variety of talks and publications and during each meeting there was a presentation on the use of music in a variety of settings. It is worth noting that the topics presented at these meetings covered an enormously broad spectrum of work and the eclectic nature of the work might not have helped to identify a specific definition of music therapy in the UK during these initial stages of the organisation. The variety of publications mentioned in the minutes of the Society's first AGM included 'percussion playing, the response of severely retarded children to music, music and crime, music for old people and music making in an Australian prison.'⁵³

Alvin had recognised that the changing attitudes towards health and education was an advantage for the founding of a music therapy society. Her perception that holistic and preventative medicine was a fast growing section of the health service fitted well within the ethos of music therapy:

Preventive medicine aims at protecting people whose health is at risk, before they fall ill. The healthy factors which can help man to keep a same balance between body, mind and emotions are those which answer his social, intellectual and emotional needs. Throughout life man must find adequate means of communication and self-expression. Music may be one of those especially because it can follow man's mental and emotional maturation and influence his behaviour at any time of his life, as a child or an adult.⁵⁴

⁵²The Chairman was William Robson; Hon, Secretary-Treasurer, Juliette Alvin with a total of 6 other executive committee members.

⁵³At the first Society for Music Therapy and Remedial Music AGM, (17.10.1959), H. Lowery (Principal of South West Essex College and School of Art) gave examples of work ranging from 'the hypnotic effect on man of a repeated beat on a drum, to the awe-inspiring effect of the Baroque style that is reflected in Bach's organ music.' See the Society's bulletin, Winter 1959, p.9

⁵⁴Alvin, *Music Therapy* (1991), p.100

However, even at the first General Meeting there were comments regarding the difficult reception music therapy was receiving by sceptical medics:

The complaint of doctors against music is that it is recalcitrant to scientific treatment and cannot be used as tested drugs or other means. But Mr Howes is convinced that there is other knowledge than scientific knowledge, and that we must not deplore this. Medicine itself is not a science but an art. Musicians and doctors practice an art and they can work in the same way. So we can believe that music therapy has value, even if it is incalculable in its results.⁵⁵

The membership of the Society grew each year: from 50 members in 1958 to 90 in 1959 and 130 in 1960. This growth and the interest taken in the first conference⁵⁶ was helping the Society to gain greater recognition and forge links with allied organisations. In the 1961 there was a list of organisations with which the Society was in contact which included the National Association for Mental Health, The British Council, the National Spastic Society, the Guild of Teachers of Backward Children, the London Council for Social Services, the National Association for Mentally Retarded Children, the Council for Music in Hospitals and the Central Council for the Welfare of Cripples.⁵⁷

Alvin explained that the Society 'began as a centre for the diffusion and study of music therapy and as an information group, holding meetings, conferences and lectures, and publishing conference papers'⁵⁸ and within five years the Society noticed that it was receiving more enquiries from the public seeking information. The first training courses run by the Society were well attended,⁵⁹ and the increase of the membership to 240 by 1962

⁵⁵Report of a talk given by Frank Howes at the Society for Music Therapy and Remedial Music Inaugural General Meeting (3.5.1958). See the Society's bulletin, Summer 1958, p.5

⁵⁶The first conference was held on 14.10.1961 at the Royal Academy of Music and was entitled 'Music Therapy in Hospitals and Hospital Schools.' See the Society bulletin, Winter 1961

⁵⁷See the Society's bulletin, Spring 1961

⁵⁸Alvin, *Music Therapy* (1991), p.157

⁵⁹The first 2 day course was held on 14-15.4.1962 at the London University Institute of Education, and was attended by 65 people. There is a record of a training course being financed by the Association for Music Therapy in Hospitals, which was described as 'an organisation sponsored by Madame Yolande Irion's Musicians' Emergency Fund in New York.' The first of these training courses was held at St. Bernard's Hospital and the second at Horton Hospital. Horton Hospital had the first music therapy centre in the country which was opened in December 1961. See BSMT bulletin, Summer 1968

encouraged the executive committee to consider a stable future for the Society. The Society's bulletin published in Spring 1962 stated:

... the Executive Committee has been appointed a sub-committee under the chairmanship of Dr. Strom-Olsen, M.D., D.P.M., Physician Superintendent of Runwell Hospital, and representing Music, Medicine and Education, to consider the whole question of the position, recognition and status of music therapists, and to draw up, for discussion, a detailed scheme of training, together with recommendations regarding the personal and professional qualifications needed for entry on such a course of training and the qualification to be given when it is successfully completed. We feel that the relevant authorities we must approach before such a scheme can become in any way official are likely to treat our suggestions with greater understanding and respect if we can produce a document which shows the seriousness of our intent, and the extent of our awareness of the proper requirements, administrative, musical and medical, which such a scheme will involve.⁶⁰

After only four years the Society recognised that it needed to seek support from external authorities in order to gain respect. This view links with Larson's theory that gaining recognition and respect is an important part of the process of professionalisation. Greater respect from allied health professions for music therapy can help to increase the opportunities and job prospects for music therapists. Bruscia stated that the music therapy profession is being co-developed by music therapists and those outside the profession. The profession has had to recognise that, without positive respect from allied health professionals, the field of music therapy might not expand or develop.

From the founding of the Society one of the main purposes was seen as the dissemination of information which included the education and training of music therapists. Full-time post-graduate training was seen as a long term goal for the Society and, whilst shorter courses which did not lead to qualification were being conducted, the Society was negotiating with the Guildhall School of Music and Drama in London for the introduction of a full-time post-graduate course. The Society was aiming for 'official recognition of the Course by educational and medical authorities with a diploma, grants available to post-graduate students, and acceptable rates of pay on a sessional basis for trained music therapists.'⁶¹

⁶⁰See the Society's bulletin, Spring 1962, pp.4-5

⁶¹Jack Dobbs, the Society's bulletin, Spring 1965, p.5

This comment by the Chairman of the Society, Jack Dobbs, identified two crucial issues that formed the basis for much of the Society's focus: the validation (and recognition) of music therapy training and the opportunities for stable working conditions.

Training: The Early Years

The Society of Music Therapy and Remedial Music was keen to instigate the training of music therapists. The introduction of a course validated by a university was thought to be beneficial not only to the students but also to the Society itself. Wigram, Odell-Miller and Oldfield noted that Alvin was keen to establish a post-graduate training which would be held at a music college because she wanted to attract more mature students who also had good musical ability.⁶² Larson was clear that the acquisition of knowledge is one of the most important developments in the project of professionalisation, labelling this core element of the process, 'the production of professional producers.'⁶³ In other words, a profession needs to encourage impressive professionals through top class training in order to secure the strongest foundations from which it can gain market control and social mobility.

Alvin wanted the training to be of the highest quality because she wanted music therapy to be of the highest quality. Larson's theory focuses on the concept that high quality of training would increase the social status and finances of the students. Her theory also suggests that the profession itself would also benefit because there would be a perception of a stable and financially and socially impressive organisation. Her theory does not comment on how the high quality of training might support the clients. Therefore her theory of the process of professionalisation is biased towards the advantages for the profession. However, the music therapy profession claims to be biased towards the benefits for the clients and I argue that the professionalisation of music therapy has supported both the clients and the profession.

⁶²Odell-Miller, Helen, Oldfield, Amelia, and Wigram, Tony, *Music Therapy - A Perspective on Training in Great Britain, and its Relationship to Other Developments in the E. E. C.* (unpublished paper, Anglia Polytechnic University, Cambridge, 13.5.1990) Document held within the archives at the Music Therapy Department, Anglia Polytechnic University, Cambridge. File B:2

⁶³Larson, *The Rise of Professionalism: A Sociological Analysis* (1977), p.50

The Chair of the Society noted that the organisation had started 'with nothing more than conviction of ideas and a sense of purpose'⁶⁴ with no reference to any desire to move towards professionalisation. As the Chairman stated, '[o]ur Society has never meant to be a professional body of music therapists,'⁶⁵ preferring to focus on offering publications, information and a Diploma Course. It is unclear, therefore, what the Society perceived to be the goal in introducing a Diploma Course. In fact, the Chair had already contradicted himself by commenting on the importance of the introduction of the post graduate course in music therapy thus:

... suitable students who are able to complete a full-time course will be given a diploma. This means that we are on the threshold of official recognition of Music Therapy as a profession ... recreation, education, healing, and research connected with medical or psychological treatment ... [a]wareness of these four stages ... is essential to our maturity; and concentration on real research is vital to our future.⁶⁶

The introduction of the Diploma course had a large impact on the development of the music therapy profession but it seems that the implications of the founding of the course were not fully recognised by the Society at this time.

The Introduction of a Post-Graduate Training Course

The Guildhall School of Music and Drama music therapy course had a limited number of places which automatically created a division between those who were deemed suitable to become professional music therapists and those who were not. The strength of belief in the need for qualified practitioners can be seen in a comment made by the Principal of the Guildhall School of Music and Drama in which he said that 'more harm than good might result from the efforts of untrained people.'⁶⁷ The Guildhall Course was approved by the

⁶⁴See the Society's bulletin, 1963, p.1

⁶⁵BSMT AGM (25.11.1972). See minutes within BSMT bulletin, Spring 1973

⁶⁶BSMT bulletin, Spring 1967, p.1

⁶⁷Address given by Allen Percival, at the BSMT AGM (2.11.1968). See the Society's bulletin, Spring 1969, p.13

Department of Education and Science within two years of its founding which offers further evidence that the qualified music therapists were gaining recognition and approval.⁶⁸

The most significant aspect of training is the acquisition of specialist knowledge and the content of the course was developed with the help and advice of a number of specialists in the field. The course included:

Instrumental practice - improvisation - keyboard harmony - sight reading - the psychology of music ... [there are] a series of 11 lectures and seminars each term at the Guildhall School of Music. The main subjects are: elementary physiology - child development - mental and physical disorder - human relationship. There is a tutorial every week for the full time students [there were also some part time students]. These are also required to follow a University of London extra-mural Course of 24 lectures on Elementary Psychology.⁶⁹

As well as Juliette Alvin, Margaret Johnson was also a tutor on the course and the end of year examiners were appointed jointly by the Society and the Guildhall. By 1973 the course also included '[c]linical practical work ... in hospitals, clinics, rehabilitation centres, special schools and so on under the supervision of a qualified music therapist.'⁷⁰ Alvin indicated that, within five years of the introduction of the course, the lecturers were more eminent and that the assignments were more rigorous. The students were assessed throughout the year with a viva voce final examination 'in front of a panel of examiners consisting of a psychiatrist, an expert in special education and a therapist. Their decision is final. There is also an oral examination given by the professor of the Course in Psychology.'⁷¹ The information Alvin offered to describe the course strongly emphasises the highly specialist and intensive nature of the training. There is a sense that she was wanting to prove that music therapy training was particularly rigorous allowing only a small number of individuals to qualify the LGSM (Music Therapy) from the Guildhall. Thus the music therapy profession was already starting to establish a clearer boundary between qualified and unqualified individuals.

⁶⁸The music therapy course at the Guildhall was finally approved by York University in 1986.

⁶⁹BSMT bulletin, Winter 1967/68, p.8

⁷⁰BSMT bulletin, Summer 1973, p.19

⁷¹BSMT bulletin, Summer 1973, p.20

Bruscia noted that a 'necessary step in the development of any profession is an identification of the specific areas of knowledge, skill, and ability required by its practitioners. Such competency requirements serve a health profession such as music therapy in several ways:

- a) They give the profession its unique identity and provide boundaries for distinguishing the roles and responsibilities of its members from those of other professions.
- b) They establish educational objectives and determine the curriculum for the training of professionals.
- c) They provide standards and criteria for evaluating academic and field training programs.
- d) They provide a basis for evaluating the qualifications of individuals seeking entrance into the profession.
- e) Most importantly, they ensure the rights of clients to receive effective treatment by well-qualified professionals.⁷²

These points emphasise the importance of high levels of competence and the final point recognises that this will benefit the clients themselves. This confirms my argument that the music therapy profession has engaged in the process of professionalisation to support the needs of the clients as well as support the growth of the field of music therapy.

The development of a diploma created a division between those who qualified and those who were unqualified which Witz states gives rise to four different attitudes regarding this segregation:

1. **Exclusionary closure:** This simply describes the fact of the exclusion of non-qualified individuals.
2. **Demarcationary closure:** This describes a firmer attitude, stating not only that there are excluded, non-qualified individuals but that also there are clear boundaries set between qualified and non-qualified individuals.
3. **Inclusionary closure:** This describes the desire for excluded parties (in other words, non-qualified individuals) to find strategies for altering the boundaries.
4. **Dual Closure:** This suggests that excluded parties attempt to carve out their own profession.⁷³

⁷²Bruscia, Kenneth, Hesser, Barbara, and Boxill, Edith, 'Advanced Competencies in Music Therapy,' in *Music Therapy* (Vol. 6a (1):1986), p.57

⁷³Anne Witz, *Professions and Patriarchy*, (London: Routledge, 1992) cited in MacDonald, *The Sociology of the Professions* (1995), pp.131-133

The term closure is defined by Walby and Greenwell as follows:

Closure is the process through which an occupation controls entry into itself, and is a practice particularly well developed in professions. Closure involves a set of practices whereby an occupation creates a monopoly over its skills by both controlling entry to training and membership, and by preventing others from practising their trade who have not acquired recognised membership. This monopoly enables the occupation to raise the price of its labour, and is the key to the enhanced rewards and privileges of professions.⁷⁴

Witz's first two points highlight the strength of influence that qualified individuals can enforce over non-qualified individuals. However, the latter two points emphasise that there are situations where non-qualified individuals can influence the situation. Larson noted that, so long as the non-qualified workers protest as individuals, arguing for their own personal gain, and are not organised enough as a group together, there is little danger that they will make much impact against the qualified party.⁷⁵ I note that the music therapy profession in the UK has developed firmer boundaries between qualified and non-qualified individuals suggesting that it has moved from exclusionary closure to demarcationary closure. In this dissertation I have not attempted to explore the attitudes of the non-qualified parties but the relationship between the music therapy profession and other related professions will be discussed later with particular reference to the developments surrounding Community Music Therapy.

This chapter has already explored the acquisition of professional (esoteric or abstract) knowledge, accessible to only a small and élite group. The Society and the Guildhall School of Music and Drama were only willing to offer a place on the training course if the applicant had adequate personal and academic qualifications⁷⁶ and Larson suggested that this is a 'monopoly of expertise in the market.' A profession is made stronger if it is able to define the technical knowledge and also be able to control those who are allowed to train and thus to gain this technical knowledge. To clarify this point she wrote:

⁷⁴Walby, and Greenwell, *Medicine and Nursing, Professions in a Changing Health Service* (1994), p.63

⁷⁵See Larson, *The Rise of Professionalism: A Sociological Analysis* (1977), p.237

⁷⁶See, BSMT bulletin, Spring 1967, p.1 which stated that 'It remains for the right students to offer themselves for training.'

... power, which goes far beyond mere technical autonomy, derives from monopoly; a monopoly of competence legitimized by officially sanctioned 'expertise,' and a monopoly of credibility with the public. Of the two, the first is more important.⁷⁷

Gaventa and Cornwall commented that 'power and knowledge are inextricably intertwined.'⁷⁸ However, rather than focus on a combative type of power, they suggested that the power that comes from gaining knowledge could, in this instance, be used for 'strategies of awareness building, liberating education, promotion of a critical consciousness overcoming internalized oppressions.'⁷⁹ Stige's ideal of field-independent music therapy research fits into this view. Although he recognises the existence of the political struggles surrounding the development of the music therapy profession, he expresses a desire for a section of the field of music therapy which is not included within combative, political power struggles.

Larson stated that aspiring professions would see the validation of training courses by external parties (eg. universities) as a method of gaining more acceptance. This would lead to more power and influence because it would demonstrate that a profession had proved its impressive and effective training to those outside the profession. Freidson suggested that '... the longer, more formal, and the closer the training is to the university, the higher the position in the division of labor.'⁸⁰ The Society was keen to have the course 'come within the jurisdiction of a University ... [because it is] the one institution in which all the various disciplines involved - educational, medical and musical, can be found.'⁸¹ Although formal validation from universities could help increase public respect for music therapy Larson noted that the profession would lose some independence and she wrote:

⁷⁷Larson, *The Rise of Professionalism: A Sociological Analysis* (1977), p.38

⁷⁸Gaventa, John, and Cornwall, Andrea, 'Power and Knowledge,' in *Action Research* (London: Sage, 2001), p.70

⁷⁹Ibid., pp.70-71

⁸⁰Freidson, *Profession of Medicine. A Study of the Sociology of Applied Knowledge* (1970), p.55

⁸¹The Society's bulletin, Autumn 1965, p.7

Despite the apparent independence of the professional providers, these special markets required institutional guarantees, which tied them closely to the state - in particular, to a state-controlled system of education and credentialing.⁸²

Although the Society of Music Therapy and Remedial Music had not considered that its role was to instigate 'professional' activities it had nonetheless been proactive in the professionalisation of music therapy. The Society was receiving numerous calls asking for the services of a qualified practitioner⁸³ and this may have motivated the Society into founding the first training course. The Society's Chair, Jack Dobbs, made the following speech which is worth quoting at length:

... [and now] to the growth of its [The Society's] sense of purpose and of the understanding of its function in society. At each stage it has consolidated its position before moving on to the next one, and it has derived its strength from the quality of its work and the value of its contribution to the community. Such organic growth cannot be hurried if it is to be healthy: it demands patience. Some of you, I know, have been disappointed by the Society's rate of progress in certain directions, and there have undoubtedly been set-backs and periods when its momentum has slackened. Nevertheless it is surely a matter for thankfulness that within the first decade of its existence the Society has reached a stage where it has achieved international recognition, and has entered into partnership with one of the leading national music colleges to establish the first full-time diploma course in the country ... The Society was founded partly to meet the need of isolated workers who wanted opportunities for the sharing of ideas and experiences, failures and successes ... We are becoming recognised increasingly not only as a Centre for the study and practice of Music Therapy, but as a National body that speaks professionally on behalf of music therapists and for music teachers in special education.⁸⁴

Image, Research and Literature

Even from the founding of the Society for Music Therapy and Remedial Music there was a sense of pressure to provide evidence of the efficacy of music therapy from external organisations and individuals and this was highlighted at a conference on Music in Psychiatric and Social Rehabilitation in 1963. Dr. Donald Blair stated:

⁸²Larson, *The Rise of Professionalism: A Sociological Analysis* (1977), p.216

⁸³See the Society's bulletin, Spring 1965

⁸⁴The Society's bulletin, Winter 1967/68, p.4

... psychiatrists as a whole were slow in taking an interest in music therapy ... it was difficult to satisfy the demand for scientific proof of the effectiveness of music therapy. It was unlikely that higher aesthetic reactions would ever be measurable in scientific terms.⁸⁵

There was a sense of that, at some point in the future, research would need to grow out of the training courses which would hopefully offer yet more evidence of the validity of music therapy.

In developing the work of our Society, unknowledge [sic] can be overcome. Suspicion is our chief enemy, for suspicion stands in the way of launching out into the unknown ... I suggest that the time will come when we shall have achieved a more precise, a more scientific approach to Music Therapy.⁸⁶

Whilst James Denny's paper focussed on the need for a more critical analysis of music therapy it did not suggest that there was a need to prove the efficacy of music therapy to those outside the profession. Instead Denny suggested that this more in-depth analysis was needed for music therapists to share their knowledge with each other. Sharing information and knowledge between practitioners was tentatively commented upon in 1964:

The time may not have come yet when wide surveys and systematic experiments would be possible ... [b]ut the pooling of facts and experiences might bring nearer the realization of a general order behind fragmentary observations.⁸⁷

Leslie Bunt and Sarah Hoskyns noted that the first research papers tended to be descriptive case studies which, although they served to highlight the existence of the young music therapy profession in the UK, Bunt and Hoskyns suggested that 'a further refinement of descriptive evidence within an experimental framework is needed.'⁸⁸ Whilst music therapy research projects in the USA were establishing carefully controlled experiments using exacting quantitative methodology, the research in the UK focussed more on the creative

⁸⁵The Society's bulletin, Summer 1963, p.3

⁸⁶Address given by James Denny, at the BSMT AGM (6.11.1971). See BSMT bulletin, Spring 1972, pp.23-28

⁸⁷The Society's bulletin, Spring 1964, p.1

⁸⁸Bunt, Leslie, and Hoskyns, Sarah, 'A Perspective on Music Therapy Research in Great Britain,' in *British Journal of Music Therapy* (Vol. 1 (1): 1987), p.3

experience of the therapeutic environment which Bunt and Hoskyns felt might not support the growth of the profession:

If not checked, this line of approach could lead to inward-looking frameworks and professional isolation, thus preventing a more open and questioning attitude with respect for other theoretical positions.⁸⁹

Although there was a belief that research was an important activity, not only for the internal health of the discipline of music therapy but also for the external validity of the profession, there was not a clear sense of how to achieve effective research work. In terms of gaining external validity and credibility the Society was taking more time to establish a training course and to extend its contacts with other institutions. The Society recognised that it needed to solidify its public image and it was during this time that it became aware of its need to re-name itself, as a sign of its changing role and focus. On the 28th January 1967 the Society voted to change its name to the British Society for Music Therapy (BSMT). The rapid launch of the first professional course and the change of the Society's name was explained at the 1967 AGM:

A change of name had become necessary because of our growing international contacts and the consequent desirability of avoiding confusion of identity at international gatherings with societies from other English-speaking countries with similar names ... The Executive Committee felt that the right moment for this had come during the last year with the unexpectedly speedy launching of the new full-time diploma course at the Guildhall School of Music and Drama.⁹⁰

Jack Dobbs explained the importance of clarifying that the Society focussed on British music therapy. However, Dobbs only mentioned tangentially the reasons for dropping the words *Remedial Music* from the title. Throughout the Society's literature little was mentioned regarding this area of the work despite the fact that, in the Spring 1972 bulletin, it was noted that it was good to have two distinct professions within one organisation. I suggest that the effort and energy given to establishing the music therapy profession left little room to invest time in remedial music and that, in reality, once the music therapy training course was established at the Guildhall, there was little inclination to support this section of the work.

⁸⁹Ibid., p.4

⁹⁰BSMT AGM (28.10.1967). See BSMT bulletin, Winter 1967/68, p.3

The field of music therapy had been developing rapidly and the Society had spent much time helping to clarify and define its existence. Many of the activities fit within Larson's theory of the process of professionalisation despite the fact that the Society had not explicitly stated that this was its intended goal. It had, for example, helped to found a validated training course which had in turn supported the beginning of the monopolisation of a market and the development of professional knowledge. Larson stated that these developments were fundamental to the success of an occupation wishing to grow. She wrote:

The form that the modern profession takes after the industrial revolution is that of corporate projects attempting, first of all, to organize 'production' for a special type of market and to gain in it quasi-monopolistic control. Given the singular nature of the 'commodity' to be exchanged, the organisation of production is concerned not with an inanimate product, but with the selection of producers or providers of services. The end-point of this primary aspect of professional organization is, therefore, the monopoly of relatively standardized education.⁹¹

In the following chapter I shall focus on the continuing development of validated training courses and will pay particular attention to the issue of standards or standardisation to which Larson alludes. This is an issue which has particularly concerned the proponents of Community Music Therapy and will therefore be investigated in the remaining chapters of this dissertation.

Conclusion

In this chapter I have explored the circumstances, social and professional, that led up to the founding of the Society for Music Therapy and Remedial Music. Ansdell, Tyler and Alvin demonstrated that there were a number of music projects being conducted during the first part of the twentieth century which were forerunners to modern music therapy. Certainly the founding of the Society for Music Therapy and Remedial Music indicates that there was a growing interest in the use of music as a therapeutic form of treatment.

I have also noted the theory that organisations and professions tend to develop at a point in time when circumstances enable them to survive. I have noted that patients were gaining a greater awareness of different treatment procedures available and the music therapy

⁹¹Larson, *The Rise of Professionalism: A Sociological Analysis* (1977), p.78

profession recognised the needs and changing preferences of the clients it aimed to serve. The music therapy profession had been able to evolve due to the pioneering work of music therapists which resulted in the founding of the Society.

The development of the first training course leading to qualification emphasised the growing desire for a structured understanding of the discipline. It is unclear how much the Society recognised what impact a formal training course would make on the profession and I have cited conflicting comments made by the Chair of the Society about the desirability of professional status for music therapy. However, the introduction of the first formally validated training course produced qualified music therapists equipped with more technical knowledge with which to monopolise a specialist market. Despite the potential power that this knowledge can offer I continue to argue that the music therapy profession has needed to consider the requirements and preferences of the laity (ie. clients, carers, employers etc) in order to survive. One of the main issues raised in Chapter Two was the need for a profession to gain the trust of the public:

... trust is essential in any situation where knowledge is held by a minority but relied upon by a body of people who are not party to that knowledge. Experts must therefore create and sustain trust between themselves, their knowledge, the lay public and those groups that sanction activity in a society, namely the government and strategic élites (in this case the established medical profession.)⁹²

Larson offered a view of professions 'spurred to organize by the competition for prestige, a resource which they aim at converting into monopolistic power in their markets.'⁹³ Although this seems rather mercenary, she tempered it by stating that service is the prime driving incentive, followed by economic gain, and she called this the 'civilizing function.'⁹⁴ Again I suggest that the desire by the music therapy profession to self-promotion has been tempered by this civilizing function.

⁹²Cant, Sarah, 'From Charismatic Teaching to Professional Training: The Legitimation of Knowledge and the Creation of Trust in Homeopathy and Chiropractic,' in *Complementary and Alternative Medicines - Knowledge in Practice*, eds. Sarah Cant and Ursula Sharma (London: Free Association Publishers 1996), p.45

⁹³Larson, *The Rise of Professionalism: A Sociological Analysis* (1977), p.69

⁹⁴Ibid., p.58

I have suggested that the work of the Society has engaged with some early stages in the process of professionalisation as outlined by Larson such as the creation of a formal organisation, the development of accredited training courses, the monopolisation of professional knowledge, and the establishment and maintenance of a market. The next chapter will consider the period which Ansdell describes as ‘the professionalisation and institutionalisation of Music Therapy in Britain.’⁹⁵ This may be in part because a second organisation, the Association of Professional Music Therapists (APMT), was introduced at a point when qualified music therapists recognised a growing need for professional support which will be explored in the next chapter.⁹⁶ The work of the APMT has focussed more on the needs of the profession and the professionals and can be seen to have engaged with the process of professionalisation more intensely.

⁹⁵Ansdell, ‘Community Music Therapy and the Winds of Change - A Discussion Paper’ (2003), p.114

⁹⁶BSMT AGM (25.11.1972). See BSMT bulletin, Spring 1973, p.22. The first mention of a need for a professional association for music therapy occurred in 1972 although the Association of Professional Music Therapists (APMT) was not founded until 1976.

Chapter Four: The Professionalisation of Music Therapy in Britain: 1976 - 1990

‘... there was constant reference to [music therapy] ... as an *emerging* profession. I feel ... with increasing confidence, that we have *emerged*. We are observed, listened to, respected and probably, our best testimonial of success, we are employed!’ (italics in the original) Wigram, APMT AGM minutes, (7.11.1981)¹

In this chapter I shall explore the development of music therapy in the UK from 1976 - 1990. This covers the phase which Ansdell described as ‘the professionalisation and institutionalisation of Music Therapy in Britain - dating from the establishment of professional associations, training, and career structures.’²

Possibly the most significant development for music therapy in the UK in 1976 was the founding of the Association of Professional Music Therapists (APMT). The main focus for the APMT has been the professionalisation of music therapy. Criticisms regarding the manner in which the music therapy profession in the UK has engaged with the process of professionalisation have been directed at the APMT. Also, the APMT and the training courses have been portrayed by Proctor as imposing restrictive definitions on the manner in which music therapy can be practised.³ I argue that it is inappropriate to question the professionalisation of music therapy without considering the reasons why the APMT engaged in this process and the manner in which this was undertaken.

It can be viewed that during the first few years of its existence the APMT concentrated so much on issues relating to the development of the profession that there had been little energy spent on clinical development. However, a conference in 1983 in Cambridge not only helped to redress the balance but also served the purpose of publicising and promoting the image of music therapy as a growing profession. It was a crucial opportunity for the disparate

¹Wigram, Tony, APMT AGM minutes (7.11.1981), p.3

²Ansdell, ‘Community Music Therapy and the Winds of Change - A Discussion Paper’ (2003), p.114

³Proctor, ‘Playing Politics: Community Music Therapy and the Therapeutic Redistribution of Music Capital for Mental Health’ (2004)

practitioners to come together to share and debate their work and it led to a second weekend which focussed on experiential music workshops held 18 months later.

During the 1980s there were significant negotiations between the arts therapies and the government, leading to recognised pay and career structures within the health sector and this chapter will include information on these negotiations. The art therapist Diane Waller and the music therapist Tony Wigram worked together to secure recognition of the arts therapies as separate and equally valid forms of therapy.

The arts therapies (which also included drama therapy) were keen to be accepted as health professions in their own right and not to be seen as a subsection of occupational therapy. The energy that the APMT gave to these negotiations with the medical sector was not matched by any discussions with the education or social services sectors. Therefore this chapter will focus on the developments that were occurring in the medical profession during the 1980s such as the introduction of management and internal markets in the NHS.

With regard to the music therapy profession in the UK, the Courses Liaison Committee (CLC) was established by the APMT to help support these negotiations by producing a document entitled *Basic Module of Training*. The CLC sought to demonstrate that similar standards were being exacted from each of the three music therapy training courses providing evidence of self-regulation within the profession. I will consider whether this may have instigated a sense of standardisation within the music therapy profession in the UK.

The Introduction of the Association of Professional Music Therapists

There was a suggestion at the 1972 British Society of Music Therapy AGM that a professional association may be a necessary addition to the Society to help support the growing number of qualified music therapists. As Juliette Alvin stated:

Although our Society is not an association of music therapists, now that our graduates are being recognised and employed, the time may come to form within the British Society a small unit, an ASSOCIATION OF MUSIC THERAPISTS, who would benefit from the support of the Society and form close professional contacts. We also intend to organise meetings and discussions with representatives of other therapies, such as physiotherapy, speech, occupational, art and play therapy in order

to create a team spirit beneficial to all concerned, including the patients.⁴ (capitals in the original)

Although Alvin stated that the APMT would come under the auspices of the BSMT, the APMT has always been an autonomous body and never a subsection of the BSMT. The first meeting of the APMT was held at the Guildhall School of Music in September 1976 with Angela Fenwick as the first Chair of the organisation which had a total of 21 members. There was a more stringent criteria for APMT membership than for BSMT membership as it was based on successful qualification from a recognised music therapy training course. William Goode suggested that the more élite a group perceives itself to be, the more members will feel a sense of belonging to the association. He stated that individuals would remain firmly committed to an association if there was a sense of a shared identity and set of values, that the group could define its own clearly distinguishable membership and that the members enjoyed a common language which was not understood by non members. By selecting and controlling its own membership, a professional organisation was more likely to remain stable and committed.⁵ However, Denize Christophers remembered that Juliette Alvin had found the introduction of the APMT difficult:

Juliette [Alvin] was very precious about her society. It had been her idea and she wanted the society to envelop everyone who was interested in music therapy, but she did recognise that there was the need for 'the trade union' side of the profession and she did not want to be involved with that. I think she knew then that the APMT would grow as the number of music therapists grew, but she always felt that we [the BSMT] were going to work alongside each other because we had different aims.⁶

Tony Wigram recognised that Alvin was 'very encouraging to the APMT, yet in a paradoxical way, at the same time not wanting it to become too powerful or too controlling ... she always recognised at an unconscious level the absolute need for it.'⁷ The BSMT had

⁴BSMT AGM (25.11.1972). See BSMT bulletin, Spring 1973, p.22

⁵William Goode, 'Community within a Community: the Professions,' in *American Sociological Review* (Vol. 22: 1957), p.194 cited in Larson, *The Rise of Professionalism: A Sociological Analysis* (1977), p.55

⁶Christophers, Denize, 'Historical Perspectives Interview Series,' interviewed by Helen Tyler in *British Journal of Music Therapy* (Vol. 16 (1): 2002), pp.7-8

⁷Wigram Tony, 'Historical Perspectives Interview Series:' interviewed by Helen Loth in *British Journal of Music Therapy* (Vol. 14 (1): 2000), p.6

been described as the 'parent organisation' of the APMT although, as already stated, the APMT was never a subsection of the BSMT. Alvin had been clear that she wanted the two organisations to work in collaboration⁸ and she recognised that the APMT worked to 'gain official recognition of the new profession, to safeguard the status and conditions of employment of qualified music therapists and to protect its members,' whilst the BSMT was 'a non-professional, learned body, registered as a charity.'⁹

The APMT was actively attempting to gain a firm pay and career structure for its members from its founding and this activity was significantly different from the BSMT which did not believe this to be part of its remit. The aims of the APMT as stated in the Constitution were as follows:

- a) To be a professional and representative body to establish fair pay and conditions and protect the rights and standards of qualified Music Therapists in Great Britain.
- b) To share information of interest to members via meetings and other suitable media.
- c) To have a register of members and a list of positions available to members.
- d) The advancement of therapy through music and the assistance towards further education of Music Therapists.¹⁰

This Constitution emphasises the need to support qualified music therapists. Without the guarantee of fair pay and conditions qualified practitioners may not have gained secure job opportunities. This lack of stability could have impacted on the therapeutic work itself because continuity of sessions would not be guaranteed. I argue that the needs and support of the therapist are crucial to secure stable therapy. So that, although the Constitution seems to focus on the professionalisation of music therapy, this process has a direct impact on the needs of the clients. Also, the protection of rights and standards of qualified music therapists in the UK benefits the therapists and the clients as well as the profession as a whole because it offers security and guarantees to all parties.

⁸Alvin stated, 'For 21 years we have kept our wonderful unity of purpose and our precise identity. We have avoided the split into 2 or even 3 bodies which has been deplorable in a number of countries.' BSMT AGM (24.11.1979) See BSMT bulletin, Spring 1980, p.18

⁹Alvin's final address to the BSMT (as the retired Chair) at the BSMT AGM (28.11.1981) See BSMT bulletin, Spring 1982, p.19

¹⁰APMT AGM minutes (24.9.1977), p.1

It could be argued that the Constitution is a document created internally by music therapists for music therapists. It could be seen as a public relations exercise to appease anxious clients or employers rather than a document which offers any sense of accountability. However, I suggest that it would have been irresponsible of the APMT to fail to draw up a Constitution which demanded a sense of accountability amongst its members. The issue of accountability is raised in the final chapter which explores the manner in which the music therapy profession has coped, and continues to cope, with the growing demand for accountability from external bodies.

Alvin continued to be the Chair of the BSMT until 1981/2 and retired as the Director of the Post Graduate Music Therapy Diploma Course at the Guildhall of Music and Drama only a month before she died.¹¹ There are a number of comments made within the APMT AGM minutes which indicate Alvin's discontent with the way in which the APMT was being run. For example, she was dissatisfied with the quality of the Newsletter and also felt that there could be clearer collaboration between the BSMT and the APMT regarding information on careers.¹² However, despite Alvin's preferences for closer collaboration the APMT had made a decision to respond to its own correspondence believing that the BSMT did not cover certain professional areas. Alvin wrote to the APMT in 1977 concerned that it was holding meetings without informing the BSMT. She felt that 'under these terms co-operation between the organisations becomes more than difficult.'¹³ The APMT reported that Alvin did not accept an apology:

Miss Alvin was not satisfied with this [apology] and felt that there were many instances of non co-operation between the two bodies. She felt that the Association had not yet developed a clear function and policy and its lack of identity was reflected in the Newsletter. She felt that we [the APMT] were trying to do too much in the wrong areas and that we should concentrate on professional matters rather than confusing our role with that of the BSMT.¹⁴

¹¹Alvin died on 30.9.1982, having retired as the director of the Music Therapy Course at the Guildhall School of Music and Drama at the beginning of September. See BSMT bulletin, Spring 1983

¹²APMT AGM minutes (24.9.1977), p.4

¹³Juliette Alvin, Letter to the APMT (date not known), cited in APMT AGM minutes (24.9.1977), p8

¹⁴APMT AGM minutes (24.9.1977), p8

Bucher and Strauss noted that to overlook the conflicts that can occur within professional organisations is to ignore some important developments which can evolve out of differences of opinion.¹⁵ Larson suggested that, if there were many practitioners, there would not be just one professional path.¹⁶ In the case of music therapy in the UK, different personalities within the APMT and the BSMT seemed to have had an influence on the diversity of the organisations. Alvin's strong desire was to keep all music therapy activities within Britain under one, homogenous umbrella and she had a clear vision as to how she wanted the organisations to run.

Millerson offered a list of fundamental and secondary functions of professional organisations. Both the BSMT and the APMT aimed to facilitate the study of music therapy as well as the dissemination of information, both of which Millerson considered to be fundamental functions of professional organisations. Both organisations also offered activities and social events and acted on behalf of their members on matters to do with music therapy. These, according to Millerson, are secondary functions of professional organisations. However, it was the APMT rather than the BSMT that undertook the other functions which Millerson described as being activities for professional organisations and these are:

1. To qualify [those who have successfully completed recognised training courses].
2. To register competent professionals.
3. To promote and preserve a high standard of professional conduct.
4. To raise professional status.
5. To control entry to the profession.
6. To protect the profession and the public.
7. To act as an interest, or pressure group on behalf of its members.
8. To provide welfare benefits.¹⁷

This list mirrors the points raised in the APMT's Constitution. The APMT also introduced a code of conduct as well as a register of qualified music therapists in the UK and it is vital to recognise that these functions were undertaken not only to support the needs of the

¹⁵Bucher, and Strauss, 'Professions in Process' (1961), pp.325-334

¹⁶See Larson, *The Rise of Professionalism: A Sociological Analysis* (1977), p.41

¹⁷Millerson, *The Qualifying Associations. A Study in Professionalization* (1964), p.28

qualified music therapists in the UK but also to enhance the relationship between the profession and the public. I have also argued that these functions support the therapy work itself. A closer look at Millerson's list emphasises that professions (including the music therapy profession in the UK) have developed a need to justify, to protect and to provide evidence of trustworthiness.

Although this Millerson's list highlights that professional organisations are biased towards supporting the professionals it does also express the need to protect the public. I have already argued that the process of professionalisation can be undertaken to support the clients as well as the profession and the professionals. The APMT and BSMT archives do not document that the self-preservation or self-promotion of the profession should be to the detriment of the clients' needs. I suggest that the self-preservation and self-promotion of the music therapy profession in the UK enhances the therapy work because it helps secure a more stable environment within which the therapy can exist. The promotion and preservation of high standards, the establishment of fair pay and conditions, the introduction of a code of conduct and the Constitution all support the needs of the music therapists, the clients, employers and the music therapy profession itself.

However, Larson's theory of professionalisation does not consider fully these potential benefits for the clients themselves. Instead it focuses on the idea that professions are motivated to promote high standards of professional conduct in order to gain public trust which could then secure more job opportunities. This theory suggests that the motivating factor is the self-preservation of the profession and the practitioners and it promotes the idea that the professions themselves will benefit both financially and in status from public trust. Therefore I suggest that Larson fails to offer a full overview of the benefits that can be gained from all parties.

One element of Larson's theory of professionalisation is the acquisition of knowledge through accredited training. During the 1980s the APMT and the three training courses focussed on this issue. The Courses Liaison Committee (CLC) was founded to explore the similarities between the three training courses in order to demonstrate to the DHSS the standards of training.

Training Courses

Although the training course at the Guildhall School of Music and Drama was founded in collaboration with the BSMT, two further courses founded in the 1970s and 1980s were established without such explicit support from the BSMT or the APMT. In fact the BSMT hardly mentioned the existence of the Nordoff-Robbins course in its literature at this time with only a small advert in the Spring bulletin of 1975 for an 'advanced one year full time training course leading to a diploma in the Nordoff/Robbins techniques' which was to be held at the Goldie Leigh Hospital.

As noted in Chapter One, Paul Nordoff and Clive Robbins met at Sunfield Children's Home in Worcestershire in 1958. Their work was innovative with enormous amounts of recordings leading to in-depth research on their approach to music therapy.¹⁸ Alvin invited Nordoff and Robbins to give talks in England in 1965 and again in 1967-68 but it was Sybil Beresford-Peirce who invited them to introduce a training course in London, the first of which, in 1974, only ran for six months due to Nordoff and Robbins' commitments. However, from 1975 it ran for a full year at Goldie Leigh Hospital with Beresford-Peirce as tutor. She was joined in the subsequent years by Jean Eisler, Elaine Streeter and Jane Worthington and the course was moved to Southlands College, Roehampton Institute of Higher Education in 1977.

The Nordoff-Robbins course received charitable status in 1980 and was able to buy and convert a building in Leighton Place, London. City University formally recognised the course in 1982.¹⁹ When the Nordoff-Robbins course left Roehampton Institute in 1981, 'a new course ... emerged with a comprehensive and exhaustive syllabus, and is being run by the newly appointed senior tutor, Elaine Streeter.'²⁰ The three courses offered contrasting

¹⁸For further information on the Nordoff-Robbins approach to music therapy see Nordoff, Paul, and Robbins, Clive, *Creative Music Therapy, Individualized Treatment for the Handicapped Child* (New York: John Day Company, 1977); Nordoff, Paul, and Robbins, Clive, *Music Therapy in Special Education*, 2nd edition (St. Louis: MMB Music, 1983); Nordoff, Paul, *Healing Heritage: Paul Nordoff exploring the tonal language of music*, eds. Clive Robbins and Carol Robbins (Gilsom: Barcelona, 1998)

¹⁹See Beresford-Peirce, Sybil, *The Establishment of Nordoff-Robbins Music Therapy in London, A Short Account* (London Nordoff-Robbins Music Therapy Centre: unpublished, 1992)

²⁰APMT AGM minutes (7.11.1981), p.2

music therapy philosophies and approaches. Auriel Warwick, as Chair of the BSMT, emphasised that '[w]e must be big enough to acknowledge that differing techniques are developing and, providing they are used with wisdom and integrity, the scene should be healthy and all-embracing. The world of musicians is a varied and divergent one - it follows that the world of music therapists will be, too.'²¹

The Heads of each training course were asked by the APMT to put together a document to identify elements of basic training which could be agreed upon by all three courses, recognising that there needed to be enough flexibility for each one to include their own style and philosophy of music therapy.²² The Course Heads, Sybil Beresford-Peirce, Elaine Streeter and Juliette Alvin (who was replaced by Maggie Pickett when Alvin became too ill to attend) met to discuss the basic elements of music teaching, theoretical subjects and clinical practice which could be said to be contained within all three courses.

The initial document was divided into numerous headings: the philosophy of training courses, objectives of training courses, entry requirements (including selection procedures), examination and assessment, theory and practice of music therapy, supervision of clinical case work, musical studies (pure and applied), study and practical application of music in therapy, instrumental or vocal skills, keyboard musicianship, composition, movement, clinical studies in related disciplines, physical disabilities, psychology and psychotherapies, personal development, observation, visits, case studies and observation. Another area which was clarified was the 'requirements and standards on Music Therapy Training Courses' which focussed on the need for experienced music therapists to teach on each course. Finally the document also described the 'requirements for the provision of practical placements, the requirements for courses to appoint qualified and experienced external examiners, the common examinations standards and procedures and the minimum/maximum contact hours for a course.'²³

²¹Address given by Auriel Warwick, at the BSMT AGM (27.11.1982) See BSMT bulletin, Spring 1983, p.18

²²See APMT AGM minutes (6.11.1982), p.2

²³APMT AGM minutes (20.1.1990), p.14. These points were also explained within the APMT AGM minutes (19.1.1991), pp.26-29

The Heads of all three courses commented on their own approach within these areas and the documentation shows constant revision and adaptation indicating the amount of negotiation and debate required to undertake this exercise.²⁴ It was the Courses Liaison Committee (which was created under the umbrella of the APMT in conjunction with the three courses) that undertook these lengthy negotiations. It is important to ask whether the CLC was attempting to create standards or to standardize the music therapy profession in the UK. In order to answer this question it is necessary to offer definitions of both 'standards' and 'standardization.'

Standards and Standardization

Larson uses the term 'standardization' which she saw as a vital part in the process of professionalisation and yet it seems an uncomfortable term to music therapists in the UK. It is necessary to consider the definitions of both standards and standardization before considering Larson's theory in relation to the music therapy profession in the UK. Raymond Williams explained that the word *standard* invites a sense of 'a source of authority' or 'a level of achievement' and that its use within education implies 'assessment or grading, and was more generally associated with a concept of grading process within a hierarchy.'²⁵ Whilst standards may help to clarify levels of competence (in a more or less authoritative manner) the concept of standardization suggests restrictions and pigeon-holing. Williams' comments on the difference between standards and standardization are pertinent:

It is very significant that the popular use of **standards** - laudatory - is at odds with a popular use of **standardization** - derogatory. **Standardization** came into use in C19, from science (standardizing the conditions of an experiment) and then industry (standardizing parts). It is not controversial in these uses, but in its application to matters of mind and experience it has been widely resisted - 'people can't be **standardized**', 'teaching mustn't be **standardized**' - by, among others, those who insist on the maintenance of **standards**'.²⁶ (bold in the original)

²⁴For more information see APMT material held within the archives at the Music Therapy Department, Anglia Polytechnic University, Cambridge. File B:2

²⁵Williams, Raymond, *Keywords. A vocabulary of culture and society* (London: Fontana Press, 1983), pp.296-297

²⁶Ibid., p.298

The proponents of Community Music Therapy at the beginning of the twenty-first century have been vocal in suggesting that potential restrictions imposed by standardization contradict the creative process of music therapy.²⁷ These criticisms are explored in more depth in the conclusion. However, I suggest that the music therapy profession in the UK has been instrumental in establishing clear levels of standards but has not attempted to impose standardisation.

The Courses Liaison Committee

The CLC explored the parity between the three training courses and it is possible to consider this issue from a number of different perspectives. By identifying similarities the CLC may have enabled closer relations between the training courses. I have already noted how groups will thrive more effectively than separated individuals and, by highlighting the parity between the courses, the work of the CLC developed the attitude of cooperation. Similarly devising a code of conduct the APMT was hoping to increase a 'primary orientation to the community interest rather than to individual self-interest' [and] 'a high degree of self-control of behaviour through codes of ethics.'²⁸

It can be seen that if each member has agreed to abide by a code of conduct there might be a stronger sense of shared professional understanding between colleagues which in turn might lead to a more coherent group attitude towards music therapy work. In this sense the introduction of the code of conduct benefited the APMT as an organisation as well as the music therapists, the clients and the employers, because it helped to promote a collective sense of responsibility. William Goode noted that the more élite the group, the more members will feel a sense of belonging to the association, and he offered eight points that make up a strong sense of professional community. To summarise:

1. Members [of a professional association] are bound by a sense of identity.
2. Once in it [the association], few leave.
3. Members share values in common.

²⁷See, for example, Proctor, 'Playing Politics: Community Music Therapy and the Therapeutic Redistribution of Music Capital for Mental Health' (2004)

²⁸Barber, Bernard, 'Some Problems in the Sociology of the Professions,' in *Daedalus* (1963), p.672, cited in Johnson, *Professions and Power* (1972), p.33

4. Role definitions vis-a-vis members and non-members are agreed and are the same for all.
5. Within the areas of communal action there is a common language, which is understood only partially by outsiders.
6. The community has power over its members.
7. Its limits are reasonably clear.
8. It has some control over selection of members and thus is self-perpetuating.²⁹

In Chapter Three I explored the concept of demarcation which is the segregation between qualified and unqualified individuals. The work of the CLC clarified the demarcation between those who could or could not qualify as music therapists in the UK by defining what constituted appropriate training.

The public are reassured if practitioners have qualifications which adhere to specific standards and are required to adhere to a code of conduct and this enables the profession to gain the trust of the public. Larson was clear that 'professional services ... [have] to be *standardized* in order to clearly differentiate their identity and connect them, in the minds of the consumers, with stable criteria of evaluation.'³⁰ (italics in the original) Furthermore she explained that '[b]oth historically and logically, standardization appears to have a democratic potential.'³¹ Remembering Williams' comments regarding the derogatory nature of the term 'standardization' it may seem unfortunate that Larson used it within the context of the process of professionalisation. I suggest that she does not use the term *standardize* in a derogatory way.

The music therapy training courses have been approved both internally, by the CLC, and externally by a University or College of Higher Education and the external validation in particular will have increased the public's confidence in the profession. Torens stated that semi-professions are predominantly heteronomous, in other words, subject to both external and internal control and guidance whereas full professions tend to believe that self-regulation

²⁹Goode, William, 'Community within a Community: the Professions,' in *American Sociological Review* (Vol. 22: 1957), p.194, cited in Larson, *The Rise of Professionalism: A Sociological Analysis* (1977), p.55

³⁰Larson, *The Rise of Professionalism: A Sociological Analysis* (1977), p.14

³¹Ibid., p.42

is the most profitable method of control.³² Etzioni also noted that more semi-professionals work within organisations rather than establishing their own companies.³³ This has also been the case for music therapists in the UK and so I suggest that maintaining careful relationships with employers, clients and the general public is crucial.

As already noted, the medical and legal professions had been enjoying the *laissez faire* attitude of the government during the eighteenth and nineteenth centuries which enabled them to practise without the need for overt accountability. Full professions considered that their status implicitly showed that they worked altruistically and audit undertaken by external authorities was unnecessary. They might have argued that self-regulation was the only appropriate method of accountability because of the inability of laity to understand the esoteric knowledge of the professions. Freidson questioned this point by considering to what extent these professions took the issue of disciplining their rogue practitioners seriously. A profession's view of discipline and punishment may not equate with the demands of the clients or the government. Whilst professions might believe that losing the good opinion of colleagues is a severe enough punishment, the public may want to be sure that practitioners are restricted or even barred from their work.³⁴ Michael Eraut explained that logically 'the greater one's autonomy, the greater one's responsibility; and therefore the greater one's accountability.'³⁵

Each profession needs to understand and work within the cultural tradition in which it is based and thus provide services which are applicable and necessary for clients' and society's needs. According to Dietrich Rueschemeyer professionals tend to work with a mixture of self-regulation, client requirements and demands from the state.³⁶ As I shall argue in the final chapter, the demand for professional accountability by third parties has grown steadily

³²See Toren, 'Semi-professionalism and Social Work: A Theoretical Perspective' (1969)

³³Etzioni, ed. *The Semi-Professions and Their Organisation: Teachers, Nurses, Social Workers* (1969), p.vi

³⁴See Freidson, *Profession of Medicine. A Study of the Sociology of Applied Knowledge* (1970), pp.149-152

³⁵Eraut, Michael, *Developing Professional Knowledge and Competence* (London: The Falmer Press, 1994), pp.224-225

³⁶See Rueschemeyer, 'Professional Autonomy and the Social Control of Expertise' (1983)

during the second half of the twentieth century and the changing expectations by the public have meant that all professions have, to a greater or lesser extent, needed to reassess their obligations to the public. In short the relationship of professions with society has changed.

The document *Basic Module of Training*, instigated 'a culture ... of good standards and good practice. This meant that subsequently when other courses tried to get started they had to bring their credentials to that forum. Some succeeded and some didn't. We [CLC] were acting as a sort of regulating organ on behalf of the Department of Health.'³⁷ Rueschemeyer stated that professions have managed continuously to 'strike a bargain with society'³⁸ with regard to professional autonomy and the work of the CLC can be seen as the music therapy profession's approach to this bargaining.

Wigram noted that the main purpose for drawing up the Basic Module of Training document was to develop standard criteria for evaluating up-grading and re-grading music therapy posts. The Whitley Council, with which the APMT was in negotiation, required the information collated within this document in order to establish a clear career and pay structure for music therapists. Only those music therapists who had successfully completed further training would be allowed to take up more senior jobs and this system offered music therapists in the UK a hierarchy of posts and a sense of career structure.

The CLC was collating the information from the three courses in order to simplify the presentation to the Whitley Council. The different philosophies and course contents can be seen as differences *within* the music therapy world. The technical differences between the courses were not relevant for the negotiations with the Whitley Council and 'it would [have been] ... unexceptionable [sic] to present to the Health Service that there were three totally different methods of training, producing three different kinds of Music Therapist. They

³⁷Wigram, 'Historical Perspectives Interview Series' (2000), p.9. One of the courses which did not succeed in being recommended by the Courses Liaison Committee (CLC) was at Motherwell College, Glasgow which failed to fulfil a number of requirements made by the CLC. Short music therapy courses were also being established at the London College of Dance and also at New Avenues. Both courses were rejected by the CLC as formal, accreditable music therapy courses leading to full qualification.

³⁸Rueschemeyer, 'Professional Autonomy and the Social Control of Expertise' (1983), p.44

would be utterly confused and reject any such diversity within the profession.³⁹ As Mark Jordan wrote, 'We are a small profession, and if our voice is to be heard we must continue to speak with one voice. There is plenty of room for differences of opinion, but no room for divided policies.'⁴⁰

The Basic Module of Training document was produced because of the demands of the Whitley Council for clear information about the standards that were expected from the training courses which demonstrates the external pressure to standardise the profession. It can also be noted that the music therapy profession, or more particularly, the APMT in conjunction with the three training courses, accepted these demands and duly set about collecting relevant information. However, it was felt that the CLC would undertake this work until State Registration was established at which point the work of the CLC would become the responsibility of the Council of Professions Supplementary to Medicine.⁴¹ Tony Wigram explained that it was important that the public were made aware of the continuing work undertaken to maintain high standards:

I would suggest that it is not satisfactory to claim the necessity of music therapy because we are doing a worthwhile job and we are well qualified and entitled to good pay and conditions of service. It is not enough just to present to all the people we are trying to convince details of where we work, what type of patients or clients we see, and a fascinating account of the philosophy behind our work. We must be able to detail exactly what we do - in terms of treatment techniques, describing patients' progress, the effects of our therapy and the changes that occur.⁴²

Demonstrating Effective Music Therapy

Wigram wrote about the importance of clear communication about the effectiveness of music therapy. However, other music therapists such as Ansdell and Ruud have tempered this view with concerns that it is impossible to translate musical 'moments' into words and warn that music therapist researchers need to recognise that translating clinical music into

³⁹APMT AGM minutes (7.11.1981), p.11

⁴⁰See APMT AGM minutes (21.1.1989), p.2

⁴¹See APMT AGM minutes (6.2.1993), p.30

⁴²APMT AGM minutes (12.11.1983), p.3

verbal language will alter the essence of the work. Aigen wondered whether it was possible to treat music as a *bona fide* medium for 'the acquisition and communication of knowledge ... [to] expand the traditional use of verbal language in science to allow it to carry the meaning and expressive value of music.'⁴³

The demand for transparent accountability had already begun to impact on the field of music therapy in the UK by the 1980s and there were some attempts to tackle this issue. For example, during the mid 1980s the APMT had established a 'Terminology Group' to help identify a consensus of opinion regarding the terminology used within the profession. It was hoped that this would offer a 'unique opportunity of making our language explicit.'⁴⁴ However, there was little lasting enthusiasm for this strand of standardisation within the profession.

Fenwick also considered introducing a 'standardised form of Assessment for Music Therapy, for use within the Association [stating that] accurate records must be kept, and a standardised form might be useful. If anyone would like further details of my investigations into the frequencies of [using] percussion instruments ... I would be pleased to let them have them.'⁴⁵ Fenwick does not continue with this line of enquiry but a referral/assessment sub-committee was formed as a result of discussion held at the 1985 Music Therapy Conference in Cambridge. Alison Levinge stated that it would be more appropriate to offer an overview of the issues involved rather than present 'the recommended method of assessment/referral.'⁴⁶

In 1986-7 John Bean and Angela Fenwick wanted to promote the music therapy profession with a booklet entitled 'The Role of Music Therapy in the Education Service.'⁴⁷ Producing technical information within this document proved complicated and yet it was felt that:

⁴³Aigen, 'Music Therapy Research - Quantitative and Qualitative Perspectives' (1995), p.480. See also Ansdell, *Music Therapy as Discourse and Discipline. A Study of 'Music Therapist's Dilemma'* (1999)

⁴⁴APMT AGM minutes (18.1.1986), p.23

⁴⁵APMT AGM minutes (11.11.1978), p.2

⁴⁶APMT AGM minutes (18.1.1986), p.24

⁴⁷See APMT AGM minutes (17.1.1987), pp.13-15

[it] would be acceptable to those who, in the last resort, wield the purse-strings and have the authority to accept or condemn the work of music therapists within the Education Service ... I [John Bean] hope that it will help to clarify all our own thoughts in the area of music therapy in Special Education, encouraging all ... to adopt a unified approach - methods of referral, techniques, assessments, etc. Such uniformity (by which I do not mean that every therapist will work in the same manner, but present a unified professional approach) can only hope to enhance the status of our profession.⁴⁸

The aim of this booklet was to enhance the image of the profession. This approach may help the self-preservation of the profession but seems to endanger the individual needs of the clients. Stige argues that the clinical flexibility needed to support therapeutic relationships appropriately would be undermined if uniformity was enforced.⁴⁹

However, Bean did not suggest that clinical work should be subjected to standardisation. He suggested that a unified approach to referral and assessment procedures could enhance the public understanding of the music therapy profession. Freidson wrote, 'the professions' role in a free society should be limited to contributing the technical information men [sic] need to make their own decisions on the basis of their own values.'⁵⁰

Bean's comments could be criticised for seemingly prioritising the image of the music therapy profession above the care for the clients. I have argued that the process of professionalisation can benefit the clients. However, this will only occur if the needs of the clients are prioritised. In other words, if the music therapy profession consistently considers the needs of the clients whilst engaging in the process of professionalisation, the music therapy profession's duty to the clients will be maintained. Bean's comments seem to focus too much on the needs of the profession despite his assurances to the contrary.

It would seem that the prime function for producing standards might be to help clarity of communication within the profession and between the profession and the public and state. The CLC was fundamentally set up to help to clarify the high levels of competency within

⁴⁸Ibid., p.14

⁴⁹See Stige, *Elaborations toward a Notion of Community Music Therapy* (2003)

⁵⁰Freidson, *Profession of Medicine. A Study of the Sociology of Applied Knowledge* (1970), p.382

the music therapy profession in the UK. It begs the question to what extent the field of music therapy in the UK was acting to prove itself to those outside of itself. Stige believes that there is a political element to the profession, the professional practice and even the discipline of music therapy (although he would prefer the discipline to be spared this politicization.) Even the field of research seems to have been influenced by political issues. For example, Robert Landy explained that arts therapies need 'to take stock of current political and economic realities and of research ... and to develop strategies, forecast future directions and provide a sense of leadership to those who have devoted themselves to healing through the arts.'⁵¹ Odell-Miller offered a more direct line:

Research has to be service led in order to obtain funding and owing to this, factors other than just music therapy need to be taken into account, such as moving from clinically based practice and process-orientated research to a relevant research methodology which will look at arts therapies outcomes in general rather than music therapy in particular.⁵²

Aigen suggested that the development of some approaches to research have come about because of a desperate need to be seen as acceptable and his dissertation explored the appropriateness of different research methodology within the field of music therapy.⁵³ It was Bruscia who offered pragmatic view on this issue when he wrote:

It bears repeating that the primary mission of music therapy, as both discipline and profession, is to help clients to achieve health through music. To limit music therapy research in any way is to limit this mission in a corresponding way. If the client's health is conceived only in physical or behavioural terms, then quantitative research might be sufficient; conversely, if the client's health is conceived only in internal, covert, or experiential terms, then qualitative research might be sufficient. The problem is that to define health in such either-or terms, and to limit the goals of music therapy practice to either overt or covert goals, physical or social realities, or objective or subjective phenomena is essentially a violation of the rights of our clients to comprehensive treatment, and thus to complete health.⁵⁴

⁵¹Landy, 'Introduction to Special Edition of the Arts' (1997), p.4

⁵²Odell-Miller, 'Investigating the value of music therapy in psychiatry: developing research tools arising from clinical perspectives' (1999), p.124

⁵³See Aigen, *The Roots of Music Therapy: Towards an Indigenous Research Paradigm* (1991)

⁵⁴Bruscia, Kenneth, 'Differences between quantitative and qualitative research paradigms: implications for music therapy.' in *Music Therapy Research - Quantitative and Qualitative Perspectives*, ed. Barbara Wheeler (Phoenixville: Barcelona, 1995), p.73

It is this holistic approach to health treatment that the field of music therapy has endeavoured to promote. Although such an approach towards health might not have been popular during the first half of the twentieth century its appeal has been growing during the second half of the century. The medical profession has had to recognise the changing attitude towards complementary medicines. It is worth noting that, whilst the British Medical Council was dismissive of complementary medicines in 1986, it was more accepting of these treatment procedures by 1993.⁵⁵ It could be argued that this change of attitude was instigated by a desire to be perceived to be acknowledging patients' preferences. Cant and Sharma noted that 'the orthodox medical profession, it seems, is abandoning the simple discrediting of alternatives on the grounds of their unscientificity ... in favour of the role of the disinterested but experienced guide to patients in their choice in therapies.'⁵⁶

The public was turning its attention towards complementary treatments and the orthodox medical profession was having to re-evaluate its position within the health care system to keep in touch with the current public demands. From this viewpoint it would seem that both the orthodox and complementary sections of the medical profession were having to accept the changing desires of the public.

Aigen and Odell-Miller suggest that music therapy projects also need to acknowledge and work with external demands. According to them it is vital to take into consideration the practical and financial implications that may result from a research project. An example of this is a study conducted by Hilary Moss which investigated music therapy within an NHS Trust for clients with mental health issues. As well as considering the needs of the clients, the results also impacted on the employment opportunities for the music therapist.⁵⁷ It is this kind of political pressure that Stige believes undermines the potential integrity for research

⁵⁵See Cant, Sarah, and Sharma, Ursula, 'Introduction,' in *Complementary and Alternative Medicines - Knowledge in Practice*, eds. Sarah Cant and Ursula Sharma (London: Free Association Publishers, 1996), pp.1-24

⁵⁶Ibid., p.17

⁵⁷Moss, Hilary, 'Creating a new music therapy post: an evidence based research project.' in *British Journal of Music Therapy* (Vol. 13 (2): 1999), pp.49-58

because the researcher and the research is polluted by the pressure to provide evidence of 'success.'

It was the activities of the APMT which focussed on the promotion of the music therapy profession in the UK during the 1980s and 1990s. There were complex negotiations that occurred between the arts therapies and the government at this time and Tony Wigram was instrumental in this work for the music therapy profession. He stated that gaining a Certificate of Independence would improve the status of the music therapy profession in the UK:

There are still further developments that are pending, in particular the problem that we still have, as an Association, no official standing with either the Health service or the Education service. There is a great need for us to be recognized both as a body and as individuals in our various areas of work and therefore we should aim for the Certification of the Association as an official organization.⁵⁸

Trade Union Support for Arts Therapies. Developing Relations with the DHSS and CPSM

If this profession's going to go anywhere we need to take a trade union attitude to it.⁵⁹

The focus of the APMT was (and still is) to support members' professional work, with particular reference to gaining 'fair pay and conditions and protect[ing] the rights and standards of qualified Music Therapists in Great Britain.'⁶⁰ In November 1978 there were discussions within the APMT on the need for union support⁶¹ and whether music therapists ought to join ASTMS, NALGO⁶² or to accept the APMT as the role of a union. These discussions were inconclusive but the music therapist Esmé Towse did suggest that the

⁵⁸APMT AGM minutes (7.11.1981), p.2

⁵⁹Wigram Tony, 'Historical Perspectives Interview Series,' (2000), p.6

⁶⁰APMT AGM minutes (24.9.1977), p.1

⁶¹The British Association of Art Therapists was already a Limited Company and was considering joining the Association of Scientific Technical and Managerial Staff (ASTMS)

⁶²Association of Scientific Technical and Managerial Staff (ASTMS) and National Association of Local Government Officers (NALGO)

ASTMS 'would be in a position to represent us as a body if the majority of us in the NHS are prepared to join individually.'⁶³ A unanimous decision was made in December 1978⁶⁴ to encourage APMT members to join the ASTMS (which already represented speech therapists and art therapists) and it was recognised that the 'APMT is not, and will not be in the near future, large enough to have a real say in situations where, unfortunately, the power of large organisations is important.'⁶⁵

The concerns within the APMT echo an earlier debate for British art therapists. In 1967 art therapists were worried about the issues involved in joining a trade union. There was a feeling that art therapy in Britain would be viewed as a self-serving profession if it became involved with trade union issues whereas the arts therapies would have preferred an image of an altruistic service. Some years later Proctor wrote about his concerns that the music therapy profession was promoting the needs of the profession above the needs of the clients.⁶⁶ To become part of a trade union reiterated a dependence on external help which seemed to some to go against the desire to be seen as an independent and self supporting discipline. Diane Waller wrote:

Some members [of the British Association of Art Therapy] at that time [1967] were nervous about the emphasis on conditions of service and becoming part of a Trade Union, fearing that the notion of service to patients would be lost through the self-interest of art therapists. The counter argument was that unless properly qualified art therapists were employed in decent conditions with regular contracts, they could hardly be expected to serve their patients well.⁶⁷

Waller described the vulnerable nature of art therapists employment. She explained that a hospital would have to seek permission from the DHSS if it wanted to employ an art therapist and that each case was considered on an *ad hoc* basis. Other professions who came under the Whitley Council were offered much more stability and the art therapists felt

⁶³APMT AGM minutes (11.11.1978), p.3

⁶⁴The decision was made on (4.12.1978). See APMT AGM minutes (17.11.1979), p.1

⁶⁵APMT, AGM minutes (17.11.1979)

⁶⁶See Proctor, 'Playing Politics: Community Music Therapy and the Therapeutic Redistribution of Music Capital for Mental Health' (2004)

⁶⁷Waller, 'Come back Professor Higgins - Arts Therapists need you! The importance of clear communication for arts therapists' (2001), p.247

undermined by this *ad hoc* approach to their work. It was because this method of employment was cumbersome and not financially beneficial to either parties that the Management Side of the Whitley Council proposed in March 1976 that the employment of *ad hoc* professions should come in line with the grading system of the General Whitley Council of the NHS. 'Those grades which could be assimilated would then have their own career and salary structure laid down by the Council, and there would be no need for the DHSS to be involved at the time of employment.'⁶⁸

Although the Management Side of the Whitley Council felt that the art therapy profession could come under the umbrella of the occupational therapists the arts therapists were very reluctant. It was the Joint Secretaries of the Whitley Council that noted that the arts therapists' ability to diagnose fundamentally distinguished them from the work of the occupational therapists. Waller suggested that, although some practitioners may not have believed that their primary function was to diagnose or to be affiliated with psychiatrists, it would be useful to emphasise this aspect of their work in order for art therapy to be perceived as being different from occupational therapy. She stated:

The claim for being recognised as a separate discipline from OT [occupational therapy] and having direct access to the medical staff was, then, based on theoretical and clinical foundations as well as on considerations of professional status i.e. on therapists' wish to be viewed as a graduate profession.⁶⁹

This point emphasises the tensions between the discipline, the professional practice and the profession of both art and music therapy. The fields of art and music therapy were being encouraged to highlight certain aspects of the work in order to promote the profession, potentially to the detriment of the discipline and to the clients themselves. The issue of diagnosis might not have been a high priority for the clinical work and yet art and music therapy were artificially highlighting its importance in order to gain independence from

⁶⁸Waller, *Becoming a Profession. The History of Art Therapy in Britain 1940-82* (1991), p.162-163. The Whitley Council was made up of two councils - Professional and Technical 'A' and Professional and Technical 'B'. Both of these are further divided; 'A' is divided into five Committees (A-E) with each one being responsible for different professions. Professions Supplementary to Medicine were covered by Committee C whilst speech therapists were covered by Committee B. Each Committee comprised representatives of unions and professional associations and the whole Staff-Side of the Whitley Council was made up of 22 seats.

⁶⁹Ibid., p.188

occupational therapy departments. This is the kind of political action that Stige felt undermined the value of music therapy.

It seems that occupational therapists were keen to keep arts therapists within their departments because it meant that they would be seen in a managerial capacity and given higher status. However, in order to keep good relations between the occupational therapy and art therapy professions, a meeting was held at the office of the British Association of Occupational Therapists [BAOT] (on 17th March 1978) between members of both professions. Despite tensions BAOT supported the BAAT's desire for autonomy and suggested that the profession aim for State Registration and join the Council for Professions Supplementary to Medicine.

As Waller noted 'The Joint Secretaries' Report had given hope that art therapy might actually be on the road to becoming "a profession" and therefore treated on a similar level to other health service professionals.'⁷⁰ Waller recognised that these negotiations supported those art therapists working within the NHS but were not supportive of those working in Social Services, prisons or education (although it must be said that there were fewer therapists working within education and that they tended to have teaching qualifications as well). However, the decision was made to concentrate on negotiations with the Whitley Council and this decision was also made by the music therapy profession.

The ASTMS suggested to the BAAT that they needed to justify to the DHSS why art therapists should be graduates. BAAT explained that graduate training indicated higher levels of intellectual ability and showed art therapists to be comparable with other professions. BAAT was keen to be put on a pay scale comparable with the speech therapists and BAAT also made it clear to the DHSS that only those art therapists who could receive full status within the BAAT should be allowed to work within the NHS (ie. art therapists who had fulfilled the BAAT's code of conduct and been appropriately trained.) BAAT

⁷⁰Report from the Joint Secretaries (Secretaries from both the Staff and Management Sides of the Whitley Council and received by the arts therapies in October 1976) cited in Waller, *Becoming a Profession. The History of Art Therapy in Britain 1940-82* (1991), pp.171-172. Negotiations regarding pay and status with the Whitley Council and the ASTMS were conducted by Diane Waller, Andrea Gilroy (art therapists) and Donna Haber (who was Divisional Officer at ASTMS at this time).

needed to keep an eye on any new art therapy course being established, to curtail any new and unrecognised course from training art therapists.

Although nothing has been published regarding these developments for the music therapy profession in the UK the minutes of APMT meetings demonstrate that the APMT was working closely with BAAT. None of these developments were formally documented by the music therapy profession. However, unpublished archival material explains that the APMT was engaged with the same issues and the negotiations that preoccupied the art therapy profession.

Both the art and music therapy professions struggled with the negotiations with the DHSS.⁷¹ The DHSS had a particular view of art therapy and wanted 'to group art therapists with "artistic volunteers" and put them onto an occupational therapist's helper grade.'⁷² Waller wrote:

BAAT, then, had to pay attention to the 'public image' of art therapy and art therapists, and to 'relations with other professions.' Art therapists had rejected the image that the DHSS seemed to have of them, and had to engage in tactics to project their own image not only to the DHSS management but to other professions, particularly psychiatrists. This became extremely important during the campaign to counteract the recommendations in the Consultative Document.⁷³

The art therapy profession had to focus its attention on promoting its image. This self-preserving action appears to have little to do with the main work of art therapy, namely the support of the clients. However, I suggest that without the preservation of an accurate portrayal of the work of art and music therapy misunderstanding could occur. As a result, the work with the clients could suffer. Therefore it is in the interest of all parties for the arts therapy professions to promote accurately all aspects of the professions.

⁷¹Despite all the progress made with the relationship between BAAT and the DHSS a report written in January 1977 seemed to ignore totally the findings of the Joint Secretaries of the Whitley Council (from October 1976). A meeting was eventually held between the DHSS and the BAAT which highlighted the fact that the DHSS had not welcomed the report from the Joint Secretaries. See Waller, *Becoming a Profession. The History of Art Therapy in Britain 1940-82* (1991)

⁷²Waller, *Becoming a Profession. The History of Art Therapy in Britain 1940-82*, (1991), p.195

⁷³Ibid., p.196

M. W. Perry forwarded a Consultative Document from the DHSS to BAAT, APMT and BADTh (British Association of Drama Therapy) on 20th November 1978 which made the following recommendations:

The Department [DHSS] believes ... that any movement for art therapy to develop as an organisationally separate NHS profession would be both unnecessary and undesirable in terms of the needs of the service; that it would run counter to the general policy of integration of the remedial professions; that it would add to the problems of co-ordinating rehabilitation programmes; that it could result in disputed responsibilities with OT departments, many of which already extensively use art media and the services of art practitioners of various kinds, and might lead to undesirable confinement to the scope and responsibility of OTs. Similar independent status might well be sought by music and drama therapists and others, thus bringing further splintering.⁷⁴

The BAAT and APMT were frustrated that the previous recommendations by the Joint Secretaries of the Whitley Council had been ignored by the DHSS. Campaigning ensued which included lobbying MPs, other professional associations and the DHSS itself. A letter was also sent from the APMT to M. W. Perry of the DHSS (who had refused to meet with the arts therapies representatives) which was signed by 18 Consultants, 2 Administrators, 11 OTs, 8 Nursing Officers, 50 Psychologists and other Therapists and 8 Teachers who all supported the music therapy profession.⁷⁵ Another blow to the arts therapies was a letter sent by the Royal College of Psychiatrists to the DHSS. It stated that it agreed that the arts therapies should not be given independent status because 'the majority of art and music therapists are not subject to any special training requirements and disciplinary procedures applicable to the Professions Supplementary to Medicine.'⁷⁶ Eric Deakin, Minister of Health, wrote:

Concern has been expressed at the possible risk of a proliferation of new therapy professions involving the grafting of therapy training onto previously acquired

⁷⁴DHSS Consultative Document which was received by the arts therapies on 20th November 1978 cited in Waller, *Becoming a Profession. The History of Art Therapy in Britain 1940-82* (1991), pp.197-198

⁷⁵APMT AGM minutes (17.11.1979), p.4

⁷⁶Letter from the Royal College of Psychiatrists to the DHSS (March 1979. Ref. C 7/79 EFCC 74/78), cited in Waller, *Becoming a Profession. The History of Art Therapy in Britain 1940-82* (1991), p.199

artistic skills and at the danger that rehabilitation services might become too diffuse if each new therapy develops in an independent way within each hospital.⁷⁷

Larson stated that one of the stages of the process of professionalisation would be liaison with allied professionals. The APMT was working hard to secure firm pay and conditions for the music therapy profession and the support that allied professions gave was sought. Even as a combined force the three arts therapies were a small group of professionals. Gaventa and Cornwall explained that it is the responsibility of each party to ensure that their presence is recognised within negotiations because if 'certain voices are absent in the debate, their non-participation is interpreted as their own apathy or inefficacy, not as a process of exclusion from the political process.'⁷⁸

The arts therapies were collaborating to create a larger, more significant presence within these negotiations, and they were also seeking contact with other organisations for more impressive support. From its founding the APMT had questioned which other organisations may be able to be supportive. Wigram met with Dafydd Wigley, (MP for Caernarfon) who recommended that music therapists contact the All Party Disablement Group. It was hoped that, by working in collaboration with Mencap and MIND, Parliament might take more notice of the music therapy profession.⁷⁹ The music therapist Bunt and the drama therapist Jennings met and agreed that a Joint Consultative Group⁸⁰ made up of music, art and drama therapists ought to be founded to explore the relationship between the arts therapies. It drew up the following aims:

- a) For there to be an area of mutual discussion and exchange concerning the career structure between the three different professions.
- b) To present a joint policy on areas of common interest.
- c) To develop joint interests e.g. there was an offer a few years ago from the King's Fund Centre offering space for office work to all these associations.

⁷⁷Letter by Eric Deakin, Minister of Health, February 1979 to an unnamed MP, cited in Waller, *Becoming a Profession. The History of Art Therapy in Britain 1940-82* (1991), p.202

⁷⁸Gaventa, and Cornwall, 'Power and Knowledge' (2001), p.70

⁷⁹See APMT AGM minutes (17.1.1987), pp.9-10 for information regarding the questions (made by Doug Hoyle) and responses made by Ray Whitney on the 22.4.1986 in The House of Commons.

⁸⁰The representatives were Diane Waller (art therapy), Sue Jennings (drama therapy) and Leslie Bunt (music therapy)

The use of this centre as a resource and communications centre for Art, Drama and Music Therapy will be investigated further.

- d) To keep in touch with other fringe developments and where necessary make comments.
- e) To maintain joint professional standard in the work all three professional bodies are carrying out.
- f) To keep abreast with recent research developments.⁸¹

APMT was interested in approaching the Council for Professions Supplementary to Medicine (CPSM) for support, primarily because it had similar values to the APMT, and it also had government backing. Wigram reported that the CPSM would have to approve of music therapy training methods, practice and code of conduct before submitting an application to both Houses of Parliament and also the Privy Council. Wigram listed six points that the APMT would need to demonstrate to the CPSM:

- a) That the profession has reached maturity and, for example, has an established and recognised governing body.
- b) That the profession is based on a systematic body of knowledge which may or may not be wholly scientific in character which is compatible with the body of knowledge for the time being attributed to and acknowledged to be the basis of contemporary medical practice.
- c) That the profession has a mutually accepted relationship with those organisations at the time taken to represent practitioners of contemporary medical practice; and that such organisations are willing to nominate medical practitioners who are prepared to serve on a Board for the new Profession.
- d) The application organisation should have an appropriate and acceptable Code of Conduct regulating relationships with patients and members of other professions or be able to satisfy the Council that the members of the profession are willing or need to be governed by such a code.
- e) That the profession has a recognised course of training over a substantial period.
- f) That its examination are adequate and properly conducted, with particular reference to the appointment of recognised external examiners or assessors.⁸²

As a result of a questionnaire sent out in 1977-78 most of the APMT members were enthusiastic about applying to the CPSM although there were some doubts whether the APMT could demonstrate the adequacy of the training. The debate considered whether the music therapy training offered enough medical input to meet with the demands of the

⁸¹See APMT AGM minutes (15.11.1980), p.8

⁸²APMT AGM minutes (24.9.1977), p.6

CPSM, especially considering those music therapists who were working within educational settings. As a result of these concerns the APMT Committee decided to postpone making any application to the CPSM. Angela Fenwick wrote about the needs and development of the APMT at this time:

The effect of many of these events has been to encourage us to reassess our professional role in society, and our relationship with the other remedial therapies. This can only lead to greater co-operation between us - necessary in such a time as this - when Government cut-backs are so prevalent. Only those professions which present themselves in a unified and disciplined way, who are able to state clearly their aims and methods, and who are objective in their self-appraisal, will be able to bear the analysis which is being turned on them.⁸³

At a meeting on 4th December 1978 a decision was made to meet with Ted Luxton of the DHSS to 'discuss the Consultative Document on Art, Music and Drama in the National Health Service.'⁸⁴ Wigram reported that, although a change in government was preoccupying parliament at this time and thus hindering any developments regarding increasing pay and career structures, there was hope that grade and pay increases would be considered in the near future:

Demands for pay rises for Speech Therapists, Radiographers etc. are contained in a Document entitled 'The Forgotten Professions,' which has been presented to the Clegg Commission on Pay Comparability. In addition to the above professions it covers technical instructors, art therapists and helpers. Reg Bird, national officer for ASTMS, pointed out that these NHS professions have traditionally been undervalued for a number of reasons, not the least being that they are predominantly female. He added that, up to now, members of these professions have not been very militant in pressing their claims and have thus tended to be overlooked. 'The increases we ask for are not out of the ordinary' said Mr. Bird, 'but are the minimum necessary to raise these professions to the level of colleagues in the public and private sectors with similar qualifications.'⁸⁵

Professor Clegg led the Commission to investigate pay and conditions for those professions under the Whitley Council (which included *ad hoc* grades).⁸⁶ But when the Clegg Report

⁸³APMT AGM minutes (17.11.1979), p.1

⁸⁴Ibid., p.3

⁸⁵Ibid., p.5

⁸⁶*Ad Hoc* grades were those practitioners who did not come under any formal pay and

came out (March 1980) the Professions Supplementary to Medicine were not given appropriate recognition and Tony Wigram reported the music therapists reaction as follows:

March: Publication of the Clegg Commission findings. Outcry of remedial professions. Music Therapists not catered for - referred for independent negotiations with D.H.S.S. inaccuracies and misinterpretations of role of therapists.⁸⁷

Arts therapists organised one day strikes whilst ASTMS questioned to what extent the Commission had been independent. Waller met the MP Patrick Jenkin who was sympathetic to the arts therapists' plight and who suggested that the new White Paper *Patients First* might help arts therapists gain management status. Leslie Bunt quoted the discussion which took place on April 29th 1980 between the MPs, Ian Mikardo and Gerard Vaughan:

Mr Mikardo asked the Secretary of State for Social Services what steps he plans to take concerning the 1979 salary increases for art and music therapists, following the Clegg commission's refusal to recommend appropriate salary levels for them.

Dr. Vaughan: These salary levels are at present determined by the Department by relating them to the salaries negotiated for occupational therapists by the professional and technical A Whitley Council. Now that the council has agreed on a settlement of the Clegg award to Occupational therapists, new salary levels for art and music therapists will be fixed, with effect from 1 April and they will be announced as soon as possible

Mr. Mikardo: I thank the Minister for that reply. However, is he aware that this relatively small group of professional workers, who make an important contribution to therapeutic treatment, are the only public service employees who have no real negotiating machinery? Their wages are fixed unilaterally by their employers. Is it not time that this nineteenth-century Dickensian anomaly was got rid of, and that we moved into the twentieth century?

Dr. Vaughan: I am sympathetic to the remarks of the hon. gentleman on this matter. Discussions are taking place with this sort of goal in mind. I should like art and music therapists to be formally allocated to a Whitley Council, so that their pay and conditions can be properly negotiated between NHS management and the staff organisations concerned.⁸⁸

Mr Mikardo made it clear that it was unacceptable for art and music therapists to depend on the status of occupational therapists for their pay and conditions but this discussion failed

conditions schemes. Each individual case had to be brought to the DHSS for their approval. This was cumbersome and unacceptable in the eyes of those professions wishing to seek Whitley Council status.

⁸⁷APMT AGM minutes (15.11.1980), p.6

⁸⁸Hansard (29.4.1980), cited in Bunt, *Music Therapy, An Art Beyond Words* (1994), p.5

yet again to give arts therapists independent status. However, in May 1980 the DHSS published a Personnel Memorandum which restricted the employment of art and music therapists only to those who had qualified from approved training courses which was seen as a step forward for the arts therapies.⁸⁹ This enabled art and music therapists to gain firm boundaries for licence to practise and at the same time the APMT met with the ASTMS to decide on career structures.

It is apparent from Wigram's notes in the minutes of the APMT AGM meeting held on 15th November 1980 that there was much work happening behind scenes to fight for the rights of the art and music therapy professions. By October 1980 ASTMS and members of the Staff Side of the Whitley Council were all agreed that there was an urgent need to allocate appropriate pay and conditions to both art and music therapy. However, it was also necessary to convince the Management Side but it was not until June 1981 that the BAAT, APMT and ASTMS were able to arrange a meeting. The Staff Side of the Whitley Council explained the type of training that was adequate for arts therapists and this was approved by Management Side:

A qualification for entry to the grade of art therapist would be an appropriate university degree or equivalent plus successful completion of a one-year full time or two years half time post graduate course.⁹⁰

It was important for both art and music therapists to be seen to be producing qualified therapists with a high level of education which would fit in with the general perception of a profession. However, the DHSS wanted to be clear exactly what level of skills and knowledge were taught on the training courses so that it would be possible to assess grading levels. This is the information that the Courses Liaison Committee helped to collate.

In order to ascertain the skills required for the hierarchy of positions held within the NHS discussions were held. Waller and Wigram were concerned that the Management Side were

⁸⁹See Waller, *Becoming a Profession. The History of Art Therapy in Britain 1940-82* (1991), p.211

⁹⁰Ibid., p.214

going to continue to make it difficult for art and music therapists to reach Senior 1 status.⁹¹ However, after many changes and alterations to the finer details, the DHSS issued the document PM (82)6 which finalised the situation. The struggle to gain acceptance from the DHSS and secure pay and conditions had taken many months. Waller stated that this development 'produced a sense of having "arrived" as a "profession" and an end to "*ad hoc*" days.'⁹² (italics in the original)

Wigram was not so convinced that the music therapy profession had 'arrived' stating that '[t]he establishment of a career and grading structure in the Health Service has inevitably left us and the Whitley Council with this question - How are Music Therapists upgraded or promoted?'⁹³ He suggested that the fairest system for gaining promotion would be either for a practitioner to be responsible for other staff or to undertake work which demonstrated more advanced skills and knowledge than necessary for basic training.

The Whitley Council found it necessary to ask BAAT and APMT to define the requirements necessary for basic training. The *Basic Module of Training* document that the Courses Liaison Committee had drawn up enabled the APMT to demonstrate the core skills for music therapists. Those who wanted to gain higher status on the Whitley Scale would have to show more advanced levels of skills.

As a result of the acceptance of the art and music therapy professions on the Whitley Scale a Joint Staff-Management Council Grading Committee needed to be established that could assess claims for any therapists who wanted to apply for Senior 1 status or higher. The minutes of the APMT AGM held on the 12th November 1983 clearly set out the method of applications. An APMT sub-committee (consisting of Wigram, Picket and Howat) examined 'all applications sent through the system - in other words from the therapist - hospital -

⁹¹The Whitley Scale is a hierarchical grading system which is structured as follows:

basic grade
Senior II
Senior I
Head IV
Head III
Head II

⁹²Waller, *Becoming a Profession. The History of Art Therapy in Britain 1940-82* (1991), p.215

⁹³APMT AGM minutes (7.11.1981), p.11

District - DHSS - staff-side secretary - ASTMS - to the sub-committee.⁹⁴ This sub-committee was very keen that all applications should be submitted in a clear format so that as many applications could be successful. It was the intention of the sub-committee to promote as many music therapists to the level of Senior 1 or higher as was appropriate. Wigram wrote:

In this respect we are attempting to not only safeguard the standards of the profession, but also our credibility as a profession with the Health Service ... work defined as highly skilled and specialised, is work which is of a level above the basic abilities we learn in basic training.⁹⁵

As already stated Wigram suggested that there were two conditions for being upgraded: that the music therapist had responsibility over other staff and/or that the music therapist was 'undertaking work that was highly skilled and specialised, which was over and above what they had covered in basic training.'⁹⁶ It was the second point which necessitated the appraisal of the three music therapy training courses by the Courses Liaison Committee. Wigram stated:

... it is evident that we have to prepare for the Health Service in consultation with the heads of courses and their respective tutors, some generally agreed to, and defined, concepts of basic training ... The process of establishing concepts of basic training will no doubt pose its own difficulties, as the philosophies and criteria of training on the three courses are different. However it would be unexceptionable (sic) to present to the Health Service that there are three totally different methods of training, producing three different kinds of Music Therapist.⁹⁷

With regard to the applications for upgrading, Wigram was clear that there needed to be two different bodies, 'one to advise the staff side at the DHSS about queries of up-gradings, and another to advise members.'⁹⁸ Wigram explained to members of the APMT who were seeking up-grades that a hospital could not block their application on grounds of lack of

⁹⁴APMT AGM minutes (12.11.1983), p.7

⁹⁵Ibid., p.8

⁹⁶APMT AGM minutes (7.11.1981), p.11

⁹⁷APMT AGM minutes (7.11.1981), p.11

⁹⁸See APMT AGM minutes (6.11.1982), p.7

money. This new pay structure had been introduced by the DHSS and a hospital could not block the application at local level.

At the APMT AGM held on 17th November 1984 Tony Wigram gave a full report on the developments of the DHSS issues occurring during this year. He explained that, although the agreements reached between the BAAT, APMT and the DHSS had produced better pay and conditions than had existed before 1982, the BAAT and APMT were not completely satisfied. Wigram suggested that it had produced a poor career structure and that music therapists were still closely associated with occupational therapists.

The music therapy profession (and the art therapy profession) wanted to sever links with the Pay Review Body and become involved with the Professional Staff Council which also served psychologists, speech therapists, scientists, pharmacists and hospital chaplains. In order to bring music therapy training in line with psychologists there was discussion that music therapists should introduce a supervision scheme and a probationary year.⁹⁹ This would produce a method of extending the length of time needed to become fully qualified without having to extend the courses themselves. A pilot scheme for post-diploma supervision was to be run from January to June 1988 but there was little interest. Although the APMT wanted to make supervision statutory for members, it was felt that a body of supervisors was needed before any further developments could occur. The following chapter will discuss the introduction of the supervision scheme in the 1990s. Wigram summarised the discussions for moving from the Pay Review Body to the Professional Staff Council as follows:

1. To come into the same negotiating arena as other graduate professions.
2. On the Pay Review Body we had been relegated once more to the status of a 'related' or 'ad hoc' profession.
3. To break our historical but inappropriate link with Occupational Therapists, which has been damaging to us professionally
(a) because Music Therapists have sometimes come under Occupational Therapists in the NHS and

⁹⁹Training for psychology required a 3 year post-graduate course in comparison to the 1 year post-graduate training required for music therapists. For details on the initial discussion about post-diploma supervision. See APMT AGM minutes (17.1.1987)

- (b) it has given us an inappropriate grading structure, which does not enable promotion to take place owing to the nature of work, only the *numbers* for whom music therapists are responsible.
4. We have virtually no representation on the Pay Review Body, and ASTMS do not submit evidence to them.
 5. The Pay Review Body is only concerned with salary scales, and many aspects of our condition of service need improving.
 6. Pay Review Bodies are generally not good, and even though this one has come up with a reasonable award, there are two factors that influence that:
 - (i) the Government has a moral obligation to the nursing and paramedical professions for being 'good' for two years, and
 - (ii) they had already planned how to claw back the money in manpower cuts, which have been occurring over the last eighteen months.¹⁰⁰ (*italics in the original*)

A new Whitley Council was established in 1987 which meant that, yet again, the music therapy profession needed to re-state its pay and conditions requirements. Wigram suggested that the hierarchy of grades should include more levels (ie, Probationer, Basic, Senior, Principal and Principal with District Responsibility, as well as another list of Lecturer, Senior Lecturer and Head of Course) and music therapists would automatically move from probationer to basic grade after one year.¹⁰¹ He wanted 'to ensure that the profession [had] the opportunity to rise to higher grades on the basis of their clinical abilities rather than their managerial responsibilities.'¹⁰² The DHSS accepted Wigram's recommendation that music therapy needed to have a nominated Advisor on the Management Side and that it should be someone who works in the NHS already. He wrote:

The significance of this is most encouraging. After some years of difficulty due to the fact that when music therapy matters are raised at the DHSS the management side are advised by an occupational therapy advisor or psychiatric advisor, from now on they will be advised by a music therapist. It is certainly an acknowledgement that they need advice and guidance on matters relating to music therapy from the profession itself.¹⁰³

¹⁰⁰APMT AGM minutes (17.11.1984), p.11. Although the DHSS agreed that the APMT could move from the Pay Review Body this did not happen immediately due to some opposition and the simple fact that the Professional Staff Council (to which the APMT wanted to move) had not been established. See APMT AGM minutes (18.1.1986), p.17

¹⁰¹See APMT AGM minutes (17.1.1987), pp.18-19

¹⁰²APMT AGM minutes (21.1.1989), p.7

¹⁰³*Ibid.*, p.8

In fact Wigram and Waller were appointed to be responsible for evaluating up-grading proposals for the Management Side whilst Helen Odell became the advisor for the APMT members for up-grading. Because of the structural changes within the DHSS, including the disbanding of the Management Side of the Whitley Council, there was little progress made for the music therapy profession. However, more progress was made in the 1990s, which will be explored within the next chapter.

The Government at this time was making enormous changes to the National Health Service and Social Services, with many services being moved into the community. This had a direct impact on the music therapy profession which Wigram commented on thus:

It came to our notice early this year that a Government sub-committee had written a report on the transfer of paramedical services into the community, and had specifically referred to the value of music therapy work they had seen in hospitals they had visited. They pointed out the importance of continuing such therapy, but also the difficulties in relocating these services in the community.¹⁰⁴

The APMT was keen to advocate the development of music therapy posts in the community and Wigram stated that music therapists needed to do more to secure music therapy posts within the community:

It became apparent early in the year [1987] that we were not making enough effort to develop Music Therapy services, and to ensure that, as clients transfer from large institutions into the community, therapy will be set up similar to that which has been developed in hospitals.¹⁰⁵

As a result the APMT created a Parliamentary Sub-Group (which included Warwick, Bunt, Wigram, Oldfield and Odell) which was working on a 'Proposal for the Development of Music Therapy Services in Great Britain.' It focussed on the issue of moving clients into the community with the following aims:

- a) To inform the All Party Services Committee for the Disabled of the available music therapy services in Great Britain.
- b) To seek support from the Committee on

¹⁰⁴APMT AGM minutes (18.1.1986), p.17

¹⁰⁵APMT AGM minutes (17.1.1987), p.8

- Ensuring future standards of practice
- Liaising with the DHSS on the development of community music therapy services in line with the national strategy for the mentally handicapped and mentally ill.¹⁰⁶

Music Therapy In and Out of the NHS

Leslie Bunt considered the various responses to Care in the Community by practising music therapists stating that some set up 'peripatetic services, following their clients out into the community. Others became part of community-based teams, linking with other creative therapists or local paramedical services.'¹⁰⁷ Bunt himself established a music therapy charity called MusicSpace which aimed to deliver a network of services within the community. Each project within the service was reactive to the particular needs of each client group and institution in which it worked. Bunt's response to Care in the Community was based on his desire to make music therapy as widely accessible as possible, which he stated could be achieved more effectively outside the NHS.

The government had instigated the purchaser/provider split within the NHS and the Arts Therapies Department within Cambridge Mental Health Trust explored the advantages and disadvantages of working within or outside the NHS. The Arts Therapies Department felt that by working outside the NHS system it would have been offering an independent service which, the department noted, might have been more autonomous and flexible. There would be less pressure on the arts therapists to have to conform to NHS structures or other professions' terminology in order to validate the service. However, it was recognised that working within the NHS would offer support for clinical referrals, security of insurance, pay and conditions and premises. It was also felt that the NHS offered, not only practical support, but it also gave the public the perception of NHS approval of the work of the arts therapies.¹⁰⁸ The Arts Therapies Department concluded that it would be more appropriate

¹⁰⁶APMT AGM minutes (23.1.1988), p.9

¹⁰⁷Bunt, Leslie, 'Music, Space and Health: The Story of MusicSpace,' in *Community Music Therapy*, eds. Mercédès Pavlicevic and Gary Ansdell (London: Jessica Kingsley Publication, 2004), p.269

¹⁰⁸Arts Therapies Discussion Group, *Potentials for Growth of Arts' Therapies Department*, minutes of a meeting of the arts therapies department within the Cambridge Mental Health Trust. (Unpublished, undocumented, 25.9.1997). Document held within the archives at the Music Therapy

and beneficial to continue to work within the NHS system which contrasts Bunt's decision to establish an independent music therapy charity.

During the 1980s the APMT put much energy into securing pay and conditions for music therapists working within the health service. The Arts Therapies Department in Cambridge decided to remain within the NHS to ensure that it would receive these benefits. However, freelance music therapists practitioners working for other organisations could not guarantee secure pay and conditions. For example, the APMT had not engaged in such intensive negotiations with the education authorities. The disparity between the working conditions and pay of those within the NHS and those working in the education sector occurred for a number of reasons. The DHSS was making clear and precise demands on the music therapy profession to produce evidence of standards of practice. For example, the standards of training and education were examined to help clarify appropriate levels of pay for music therapists. The APMT was able to produce definite responses to the demands made because of the DHSS required specific information.

The main problem for the establishment of formal pay and conditions for music therapists working in education was that each case was independent from any other case. Whilst the Whitley Council was demanding clear information about the code of conduct and validated training courses so that it could create appropriate pay and conditions for all music therapists working in the NHS the education sector was not interested in these types of negotiations. There was little formal recognition of the music therapy profession from the education sector which left the music therapists working in this field in a vulnerable position.

Unlike the Health Service where it had been possible to negotiate one pay structure, Fenwick noted that the Department of Education tended to leave each local education authorities to set standards in a more autonomous fashion.¹⁰⁹ It was thought that seeking help from the NUT or NALGO might be useful. However, it was perceived that seeking support from the NUT indicated a link with the teaching profession which was not necessarily the image that the music therapy profession in the UK wanted. If the art and

Department, Anglia Polytechnic University, Cambridge. File B:2

¹⁰⁹See APMT AGM minutes (6.11.1982), p.9

music therapies were affiliated with the education system there was confusion as to whether they were, in fact, specialist teachers. This did not help the perception of the arts therapies. The music therapy profession did not seek support from the NUT and the BAAT decided to leave the Union in 1976.

During the 1980s there was a growing sense that music therapy in Britain needed to present an clearer image to the public. The APMT employed the skills of a company to design an effective logo and justified the work thus:

Taking the well chewed phrase 'you are what you eat' the publicity sub-committee felt that it was time to examine our own body image and decide if it was a true reflection of our inner goals and aims. To continue the analogy - with the continuing growth of our own professional body we asked - 'Are we really showing what we are made of?' having decided not - we were extremely [sic] fortunate to have contacts in high places and were able to persuade a very high powered firm to take us on ... [to help produce a Corporate Identity].¹¹⁰

The music therapy profession in the UK had made significant strides along the process of professionalisation. It had worked hard within negotiations with the DHSS and had secured recognition, firm pay and conditions and developed strong links with allied professions. The acquisition of a professional logo was a outward display of the status the music therapy profession had gained. However, this logo may have only reflected the attitude towards the profession, and not the discipline of music therapy in the UK. Bruscia wrote:

The identity of music therapy that any association projects should be consistent with clinical practice, theory, and research, rather than with any professional image demanded in the current marketplace. In other words, the profession of music therapy has to define itself according to the discipline, rather than according to its socioeconomic or political environment.¹¹¹

Conclusion

... professionalisation is a historically specific process. The period following the Industrial Revolution which enabled the emergence of this form of social power for doctors and lawyers has quite possibly passed. New aspiring professions now have

¹¹⁰APMT AGM minutes (18.1.1986), p.20

¹¹¹Bruscia, *Defining Music Therapy* (1998), p.262

the disadvantage of competing for power with other more powerful and well-established social groupings, which do not wish to cede power to newcomers.¹¹²

In this chapter I have explored an important era in the development of the music therapy profession in the UK. Reflecting on Larson's theory of the process of professionalisation, the field of music therapy made significant strides along this path. Tony Wigram was instrumental in promoting the profession and Jenkins' comments above demonstrate the struggles that music therapy was facing in order, not only to survive, but to thrive. Wigram felt that the music therapy profession could not be complacent despite successfully gaining secure pay and career structure on the Whitley Scale:

... if we only maintain this pressure and initiative as it at present stands, our achievements will be severely limited, and our reputation as a profession will eventually fade. If we increase as a body the pressure to expand, create greater awareness, and to achieve significantly more authenticity than we at present have, our acceptance as a profession will become considerably more concrete and realistic.¹¹³

Wigram recognised that the development of the music therapy profession in the UK needed to be achieved with integrity. In this chapter I have cited concerns that the process of professionalisation has disregarded the needs of the clients and therefore the fundamental values of the profession. I have argued that professionalisation can be beneficial to the clients as well as the music therapists so long as the profession is motivated by the need to support the client and not motivated primarily by self-preservation and promotion.

The APMT has been led by and for music therapists. I have considered the way in which an organisation not only supports but also encourages a sense of commitment and bonding between members. In the previous chapter I cited Richard Hall who stated that 'in order to achieve change, *there must be organisation*. Spontaneous demonstrations or collective emotional responses may be sincere and well intended, but longer-lasting movements towards change must come about through the organizational mode.'¹¹⁴ (italics in the

¹¹²Jenkins, Peter, *Counselling, Psychotherapy and the Law* (London: Sage, 1997), p.298

¹¹³APMT AGM minutes (12.11.1983), p.4

¹¹⁴Hall, Richard H, *Organizations. Structure, Processes, and Outcomes*, 6th edition (Englewood Cliffs: Prentice Hall International Editions, 1996), p.18

original) It is the APMT that has negotiated for clear pay and conditions. Those practitioners who have not benefited from these negotiations are in much more vulnerable positions. These employment situations may not help sustain secure therapy processes which can leave both the therapists and clients in vulnerable situations. The negotiations which the APMT undertook on behalf of its members helped secure employment prospects and therefore gave therapeutic relationships stability.

Another concern that has been raised about the professionalisation of music therapy has been about standardisation. This term can cause confusion because it can refer to a clarification of levels of competence but can also be used to imply compliance. Larson uses this term within her theory of the process of professionalisation. I have explored this term and suggest that, within the context of the professionalisation of music therapy in the UK, standardisation has not been employed to restrict practice. However, some music therapists are concerned that the field of music therapy has been subject to pressures to conform and these issues are explored again in Chapter Five and the Conclusion.

I have concentrated on the developments from 1976 to 1990 during which time the newly formed Association of Professional Music Therapists spent much time negotiating with the DHSS for firm pay and conditions. These activities demanded much energy and concentration from the APMT. However, there were other projects slowly evolving within the APMT and, by 1986, there were a number of sub-committees exploring other significant developments.¹¹⁵ For example, in 1987 the music therapy profession in the UK explored its position within the EEC although this became more relevant when the European Community Directive on recognition of professional qualifications came into effect in 1990. Tony Wigram, with music therapists from other EEC countries, established the European Music Therapy Committee to encourage the sharing of information and offering support.¹¹⁶ In 1985 the World Federation for Music Therapy was founded and by 1993 the European Music Therapy Committee included Belgium, Holland, Denmark, France, Italy, Spain, United Kingdom, Portugal, Greece and Germany, Finland and Sweden.

¹¹⁵For more information about the internal developments of the APMT see minutes of the APMT meetings.

¹¹⁶APMT AGM minutes (6.2.1993), p.15

In the next chapter I consider the professionalisation of the music therapy in Britain from 1990 to the present. Having spent much time securing pay and conditions the APMT now turned its attention to the legal registration of music therapists. A post-diploma supervision scheme and the introduction of Continuing Professional Development were also significant developments during the 1990s and both these developments highlight the growing concern for accountability. I have already hinted at the growth of Community Music Therapy which occurred at the end of the twentieth century and which has brought about heated discussion and debate. These debates are particularly relevant to this thesis and I shall consider them further.

Chapter Five: **Becoming Accountable: 1990 - 2003**

‘The profession as a whole is in a state of transition. The changes within the NHS, Social Services and Local Education Authorities are forcing people to look at their work in different ways.’
Simmons, APMT AGM minutes, (8.2.1992)¹

In this chapter I continue to consider the history and development of the music therapy profession in the UK and focus on events from 1990 to 2003. These developments include the introduction of State Registration, the establishment of four more validated training courses, the introduction of a supervision scheme and a Continuing Professional Development project.

Rachel Darnley-Smith stated: ‘... possibly more than ever before, APMT members have had little choice but to find out about and take note of a political happening directly related to their work - and to seek/give information accordingly.’² Certainly the developments within the NHS were having an impact on the music therapy profession as more pressure was being placed on it to engage with the issue of accountability. As the music therapist Helen Loth explained, ‘[music therapists] have found the biggest problem to be the speed of change within the NHS at the moment. The demands for information, documents and proof of effectiveness are ever-increasing and, once produced, need updating or doing in a different way.’³

Helen Patey and Rachel Darnley-Smith noted that music therapists were continuing to work together with the other arts therapy professions to support each other.⁴ As part of this process the arts therapies joined together to form the Joint Validation Board (which was renamed the Joint Quality Assurance Committee) whose main task was to identify and define the levels of expertise offered by the validated training courses. The arts therapies

¹Simmons, Mary, APMT AGM minutes (8.2.1992), p.10

²APMT AGM minutes (19.1.1991), p.1

³APMT AGM minutes (10.2.1996), p.27

⁴Darnley-Smith, and Patey, *Music Therapy* (2003), p.23

professions also became members of the Allied Health Professions Forum (AHPF) which is a larger organisation offering support to a wider range of professions supplementary to medicine.

The APMT was negotiating with the Council for Professions Supplementary to Medicine (CPSM)⁵ for support in attaining State Registration and the CPSM took over the regulations and disciplinary matters of the music therapy profession from 1st June 1999. In 1996 there was a comprehensive overview of the CPSM undertaken by an external agency. This report, by J. M. Consulting Ltd., was followed in August 2000 by a Consultation Document entitled *Modernising Regulations - The New Health Professions Council*. The Allied Health Professions Forum responded to the questions raised by this second document, and all of these documents have a direct impact on the music therapy profession and will be considered within this chapter.

The government has demanded accountability from public services and the APMT has had to engage with this issue. As Bruscia suggested, the music therapy profession is not an entirely independent body but one which has had to respond to governmental demands. The APMT has accepted the need for external support to cope with these demands and has persuaded its members that this has been necessary to secure appropriate levels of pay and conditions.

In this chapter I also explore the criticisms made by Simon Proctor who argues that the music therapy profession should not have made such strong links with the NHS. He suggests that the value system of the music therapy profession is not compatible with biomedical treatment procedures. Having studied the original documents held within the APMT archives I suggest that the APMT has not had enough power to survive without the support of external bodies such as the CPSM/HPC, the trade unions and the AHPF.

Proctor's criticisms of the process of professionalisation centred on the concern that clients' needs would be neglected if the profession primarily focussed on its own promotion. I argue

⁵The CPSM became the Health Professions Council (HPC) on 1.4.2002. There was a period of time when the CPSM handed over administration to the HPC. I shall refer to these organisations as CPSM/HPC for this transitional period.

that the APMT's prime motivation for the promotion of the music therapy profession has been to ensure that a high standard of practice is maintained for the benefit of the clients. This is something that the APMT has had to demonstrate to the CPSM/HPC (which has become the regulating body for the music therapy profession). Its main function is to protect the public rather than the professions and there are concerns within the APMT that the CPSM/HPC is not obliged to take notice of advice from practitioners and can implement new policies without reference to music therapy advisors.

The three most important developments for the music therapy profession in the UK during this period were the attainment of State Registration, the continuing growth of training and the links made with allied professions to provide support for the music therapy profession. I explore these developments in conjunction with the sociological theories on the process of professionalisation of Larson, Johnson and Light.

In order to understand some of the issues that were pertinent to the music therapy profession during the 1990s it is necessary to offer a brief overview of the general developments that were occurring between the NHS and the Government. These developments were indicative of the general attitude changes towards transparency of practice through accountability, clearer levels of professional proficiency through the introduction of Continuing Professional Development schemes and shifts in power away from the professionals and towards the clients. I suggest that, because the music therapy profession had focussed its attention on working within the NHS, the health care policy changes have had a significant impact on the professionalisation of music therapy in the UK.

It could be considered that the medical professions had had considerably more power and influence over the National Health Service prior to the introduction of general management. Mike Dent noted that about 80% of the total health costs of the NHS was generated by medical decisions taken by the doctors during the 1970s.⁶ The introduction of a new general management scheme within the NHS (noted in the previous chapter) was only one of the main changes that the Conservative government made in the 1980s. With economic

⁶See Dent, Mike, 'Doctors, Peer Review and Quality Assurance,' in *Health Professions and the State in Europe*, eds. Terry Johnson, Gerry Larkin and Mike Saks, (London: Routledge, 1995), pp.86-102

problems occurring in the 1970s the government decided that the introduction of the internal market within the NHS would help to control the expenditure of the service.

An article in *The Economist* pointed out that the 'Government is terrified that the idea at the heart of the reforms - making money follow the patient - might increase efficiency but lose votes.'⁷ Because of this, the Conservative government did not want to introduce a free market because it would be unpopular with the public. Although the government wanted to ensure that the NHS was offering value for money it recognised that the public appreciated the fact that they did not have to pay for the health service. Thus the introduction of the internal market enabled the NHS to remain free for patients whilst encouraging the professionals to work in a cost effective manner.

The NHS in the 1990s

The government stated that the introduction of a competitive environment within the NHS would encourage a more cost efficient service and promote more patient choice. As Nick Manning wrote:

There was no serious incentive for efficiency [within the NHS] ... The ethos of the service was provider-dominated with little incentives to meet the patients' needs or wants ... [and] there was insufficient accountability for the costs and quality of the output of the service.⁸

The government did not want to introduce an open, free market because it wanted to continue to have some control over the NHS and it wanted to restrict the level of competitiveness so that it could be perceived to be in the best interests of the patients and not a method of privatising the NHS for economic gain. Thus the introduction of the internal market enabled the NHS to remain free for patients whilst encouraging the professionals to

⁷*The Economist*, February 1991, cited in Butler, John, 'Origins and Early Development,' in *Evaluating the NHS Reforms*, eds. Ray Robinson and Julian Le Grand (London: King's Fund Institute, 1993), p.23

⁸Manning, Nick, 'Health Services: Pressures, growth and conflict,' in *Social Policy Towards 2000. Squaring the Welfare Circle*. eds. Vic George and Stewart Miller (London: Routledge, 1994), p.145

work in a cost effective manner. Alaszewski explained that the restructures were justified thus:

- The market is generally superior to the ballot box as a means of registering consumer preference.
- Medical care is a personal consumption good, not markedly different from the generality of goods bought by consumers.
- Therefore, if the aim is to maximize consumer satisfaction, medical care should be supplied through the market.⁹

It was the White Paper, *Working for Patients* (1989), that instigated the separation of purchasers and providers within the NHS with health authorities purchasing services on behalf of the public in their districts and the fundholding GPs purchasing services for their patients.¹⁰ The providers of services included self-governing hospitals, or agencies with professionals willing to offer their services. This new system produced much bureaucracy and it has been suggested that the amount of time and effort needed to deal with these negotiations reduced the amount of time and effort that could have been given to the patients.¹¹ Barlett and Le Grande also noted that the providers and the purchasers could, at times, have been motivated by their own agendas rather than the welfare of the clients. Whether the negotiations occur between different professionals (either as purchasers and providers) or between professions and the state each 'have a responsibility to exert influences against each other in the interests of those who use public services.'¹²

To maintain the restrictions on the NHS whilst creating some kind of competitive element to the market creates a permanent tension between purchasers and providers which, it can

⁹Lees, D. S., 'Health through choice,' in *Monopoly or Choice in Health Service? Contrasting Approaches to Principles and Practice in Britain and America*, ed. Institute of Economic Affairs (Occupational Paper no. 3: 1964), p.14, cited in Alaszewski, Andy, 'Restructuring health and welfare professions in the United Kingdom. The Impact of internal markets on the medical, nursing and social work professions,' in *Health Professions and the State in Europe*, eds. Terry Johnson, Gerry Larkin and Mike Saks (London: Routledge, 1995), p.57

¹⁰See Le Grand, Julian, 'Evaluating the NHS Reforms,' in *Evaluating the NHS Reforms*, eds. Ray Robinson and Julian Le Grand, (London: King's Fund, 1993), p.258

¹¹See Bartlett, Will, and Le Grand, Julian, 'The Performance of Trusts,' in *Evaluating the NHS Reforms*, eds. Ray Robinson and Julian Le Grand (London: The King's Fund, 1993), pp.54-73

¹²Wilding, Paul, *Professional Power and Social Welfare*, Routledge and Kegan Paul, London, 1982, cited in Richard Hugman, *Power in Caring Professions* (1991), p.27

be argued, 'raises doubts about the extent to which purchaser and providers can ever be truly free to pursue locally-based health care objectives.'¹³ Bartlett and Le Grande stated there needs to be a balance of competitiveness between the purchaser and the provider and this balance could be upset if one party monopolises the market. If the providers monopolise the market the purchaser becomes dependent on the provider with no choice or ability to 'shop around.' Carrier and Kendall explained that the purchasers of the service (ie. local authorities) are at the mercy of the self-governing hospitals (the providers) because they are dependent on accurate and honest information about the needs of the service. As Illich states:

professionals ... tell you what you need ... they claim the powers to prescribe ... they not only advertise what is good, but ordain what is right.¹⁴

This situation can be reversed if the purchaser has the monopoly over the market, which means that they would not have to respond to the providers' needs or offers. In this situation the provider may feel vulnerable if there are plenty of other alternative forms of treatment from which the purchaser can choose. As noted already, the British medical profession changed its attitude towards complementary medicines at the beginning of the 1990s and that this more positive view coincided with the growing opportunities patients had to make their own choices regarding treatment procedures. It could be seen that the medical profession, feeling threatened by the growing number of other forms of treatment from which the patient was free to choose, decided to work with these alternative treatments rather than view them as threatening competition. This would also enable the medical profession to keep these complementary treatments subordinated and thus retain the authority over them.

Working within the NHS and Social Services Systems: The Implications for the Music Therapy Profession in the UK

¹³Appleby, John, Smith, Paula, Ranade, Wendy, Little, Val, and Robinson, Ray, 'Monitoring Managed Competition,' in *Evaluating the NHS Reforms*, eds. Ray Robinson and Julian Le Grand (London: King's Fund Institute, 1993), p.47

¹⁴Illich, I., *The right to useful unemployment and its professional enemies*, (London: Boyars, 1978), p.49, cited in John Carrier and Ian Kendall, *Health and the National Health Service* (1998), p.292

The introduction of NHS Trusts had an impact on the music therapy profession as these Trusts were not obliged to work with the recommendations of the Whitley Council. Therefore the arts therapies and all the other professions who had managed to secure appropriate pay and conditions through negotiations with the Whitley Council could not guarantee their pay anymore. There were concerns that the hospitals that were moving over to Trust status would be able to pay music therapists less than was stated by the Whitley Scale. However, some Trusts were offering salaries higher than those on the Whitley Scale but there were concerns that this was only happening to secure the loyalty of the professionals. The APMT had provided evidence of standards of practice and had demonstrated the levels of competence required to work within the hierarchy of the Whitley Scale and these NHS policy changes undermined the negotiations that had taken place between the APMT and the DHSS. Emma Bishton gave a report on work issues for music therapists within the NHS in which she wrote:

The advent of local pay has enabled Trusts to make different offers for staff on Whitley contracts than for those on Trust contracts. This has happened in some Trusts - often with a higher offer being made to staff on Trust contracts to entice staff away from Whitley contracts. In addition, offers to Trust staff have often been made with considerable strings attached, leading to protracted negotiations. Common strings have been deductions in sick pay (most common by far), conversion of Stat Days into Annual Leave, changes to allowances, implementation of single pay spine.¹⁵

The NHS was exploring whether the work undertaken by well paid professionals could be conducted by unqualified people. Again it undermined the work undertaken by the CLC to demonstrate the standards required to qualify as a music therapist and it put more pressure on the music therapy profession to identify specialist skills, knowledge and techniques which could only be carried out by fully qualified practitioners.¹⁶ These changes were accompanied by a growing demand for job evaluations which David Bird considered to be 'very crude and as such ... rarely reflect small areas of employment such as music therapy to their advantage.'¹⁷ The music therapy profession joined forces with other allied health profession as a means of gaining support to cope with these demands.

¹⁵APMT AGM minutes (8.2.1997)

¹⁶APMT AGM minutes (6.2.1993), p.11

¹⁷APMT AGM minutes (10.2.1996), p.16

The APMT was also concerned that performance related pay might also be introduced. Darnley-Smith suggested that this system could be divisive because it would create tensions between staff, and between staff and management and these tensions would distract arts therapists away from the clients' needs.¹⁸ I have already cited sociological theories by Johnson and Hugman who suggested that the negotiations between the state and the professions might take the focus away from the clients.¹⁹ I suggest that the speed with which the government introduces new NHS policies may leave a profession as small as the music therapy profession struggling to cope with the demands and pressures being put on it. The main concern for critics of the process of professionalisation is that the needs of the clients could be neglected throughout these negotiations.

Because the work of arts therapists could be difficult to assess in a manner which was considered satisfactory for the NHS, the arts therapies professions have felt that they may be unfairly penalised. Proponents of Community Music Therapy have stated that it is inappropriate to work within the health system because the music therapy approach to treatment is incompatible with the biomedical methods of treatments. For example, Proctor suggested that the music therapy profession was being pressurised into conforming to the biomedical methods of providing evidence of clinical effectiveness.²⁰ These pressures might prove detrimental to the fundamental values of the work and also to the needs of the clients.

Helen Odell-Miller has written on the issues regarding the purchaser/provider split and how it affected the music therapy service in the community for adults with mental health problems in the Cambridge area. She commented that the music therapists were hoping to focus on working on long-term treatment procedures because of the perceived benefits to the patients. Concerned that this form of treatment may be seen as financially prohibitive, she approached the Director of the Purchasing Team for the local mental health service, to explain the issues involved. The Director was enthusiastic about this use of the music therapy service, not for clinical reasons, but because he was hoping that music therapy could

¹⁸APMT AGM minutes (6.2.1993), p.10

¹⁹Johnson, *Professions and Power*, (1972), cited in Hugman, *Power in Caring professions* (1991), p.3

²⁰See Proctor, 'Playing Politics: Community Music Therapy and the Therapeutic Redistribution of Music Capital for Mental Health' (2004)

fill a perceived gap in the service and cope with patients who 'might otherwise have slipped through the net.' Odell-Miller explained, '... his priorities and ours as therapists, whilst at first seemingly based at opposite ends of the spectrum of health care priorities, are closer than we might first have thought.'²¹ The music therapy service was reacting to the needs of the clients whilst the Director of the Purchasing Team was keen to demonstrate that gaps in the service were being covered. He did not perceive that the needs of the client ought to be the motivating factor in providing a service. Despite this example of a 'successful' music therapy service within the mental health community Odell-Miller highlighted her concerns for the music therapy profession as a whole:

In this era of financial pressure, particularly since the 1990 Griffiths report, it seems as if it is more necessary than ever to argue exactly why each treatment should exist, and is effective ... Our department would not have expanded if we had not said - this is why you need Music Therapy, as much, or more than, some other form of treatment. What is changing now is that with *such* financial pressure, there is a worry that in the end, only doctors and nurses will remain. Let us hope not - but unless we are prominent in management and planning strategy meetings, how can those responsible really know?²² (*italics in the original*)

These comments reflected a real concern for the music therapy profession and its need to promote the relevance of the service to those with power and influence, not only within the NHS, but also within the education service and social services.

Therapists ... are often isolated and have their own set of difficulties - in particular in negotiating pay scales, having qualifications recognised and often working within a political/social system which has ideological problems with the whole concept of 'therapy.'²³

Communications between the Music Therapy Profession and the NHS, Social Services and the Education Authorities

²¹Odell-Miller, Helen, 'Why provide music therapy in the community for adults with mental health problems?' in *British Journal of Music Therapy* (Vol. 9 (1): 1995), p.8

²²Odell-Miller, Helen, *Music Therapy - Changing Models in a Mental Health Service* (unpublished paper: March 1992), pp.1-2

²³APMT AGM minutes (10.2.1996), p.30

The APMT had developed working parties for music therapists working not only in the health service, but also social services and education to help develop firmer pay and career structures. The APMT was aware that music therapists working in social services were having to cope with the new demands imposed on them because of the introduction of Care in the Community. Local Social Services were starting to be led by Case Management Teams who would buy in services from agencies (including Health Authorities). As a result 'the role of Social Services as procurer of services ... [was] enhanced. To quote from the Act, "The interface between health care and social care is a key area in planning assessment, care management, commissioning and service delivery."'²⁴ Chris Gale explained that music therapists needed to promote the value of their services, not only to gain contracts,²⁵ but also to be careful not to come under the assessment heading of 'leisure.' Gale continued:

I would emphasise the importance of directing information to purchasers of services ... I feel we need to take a good look at the language in which our services are described, and revise accordingly, whilst not diluting the importance of the therapy ... the APMT's role could be described as 'developing access to music therapy services' rather than 'creating job opportunities for music therapists.' It is important that our role in enhancing the value of clients and encouraging choice, independence etc. is highlighted and not obscured ... the important word for us with Community Care is *initiative*, but it is vital that this be supported by a strong element of *co-operation*.²⁶ (italics in the original)

This quotation emphasises the extent to which the APMT was attempting to operate within the purchaser/provider system. Gale was keen to demonstrate that the music therapy profession focussed on the needs of the client and not on the promotion of the profession. This fits with Bruscia's belief that 'the profession of music therapy has to define itself according to the discipline, rather than according to its socioeconomic or political environment.'²⁷ I suggest that the music therapy profession was defining itself by combining the ideologies of the discipline with the needs of the profession.

²⁴APMT AGM minutes (6.2.1993), p.25

²⁵APMT AGM minutes (8.2.1992), p.24

²⁶APMT AGM minutes (6.2.1993), p.25

²⁷Bruscia, *Defining Music Therapy* (1998), p.262

The government had encouraged Social Services and the NHS in the 1990s to empower client choice and to promote client independence. This new approach fitted well with the attitude of the field of music therapy. With this new era of client choice, it would appear that the music therapy profession in the UK might thrive. Ruud suggests that the empowerment of clients, which the government promoted, has been a fundamental part of ethos of music therapy:

The question is how music therapy, as a social formation, may speak back to society, ie. how they [sic] may influence the general thinking about such issues in today's society. When health authorities talk about the role of cultural activity in forming a better pattern of health in society, they should recognise how music therapists and other art therapists have pioneered this way of thinking.²⁸

Ruud's statement suggests that the health authorities and Social Services could learn how to empower client choice and promote client independence from the music therapy profession. Ruud argues that the medical profession needs to recognise that the music therapy profession is not a subordinated but a pioneering profession.

In order to improve communication and relations between the music therapy profession and the health authorities and Social Services, Gale suggested that music therapists needed to employ the current terminology held by these more established profession. This was echoed by Steinhaus and Wright-Bower who stated that it was essential music therapists learnt to market their service effectively to health administrators. Although writing about the USA health system both the USA and UK have, to a greater or lesser extent, embraced the 'corporatization of medicine.'²⁹ They explained that, whilst many healthcare workers enter their chosen professions through a sense of altruistic service, the institutions in which they find themselves working are more concerned with 'maximum return on their investment.'³⁰ Steinhaus and Wright-Bower felt that healthcare administrators and managers focussed their

²⁸Ruud, Even, 'Music and the Quality of Life,' in *Nordic Journal of Music Therapy* (Vol. 6 (2): 1997), pp.86-97

²⁹Steinhaus, Carol S., and Wright-Bower, Linda M., 'A Conceptual Framework for Marketing Music Therapy to Healthcare Administrators,' in *Music Therapy Perspectives* (Vol. 13: 1995), p.82

³⁰Salmon, J. W., 'Introduction,' in *The corporate transformation of health care: Perspectives and implications*, ed. J. W. Salmon (New York: Baywood Publishing Company, 1994), pp.1-28, cited in Steinhaus, and Wright-Bower, 'A Conceptual Framework for Marketing Music Therapy to Healthcare Administrators' (1995), p.82

attention on the survival and financial security of their organisations and that music therapists and other healthcare workers focussed their attention on issues of client needs and growth and, as such, the two parties could find it difficult to communicate effectively.

Gale noted that arrangements between Social Services and the NHS varied from situation to situation but that 'it will be important to clarify whether music therapy is being purchased to respond to a health need or a social need, especially as services come to be costed.'³¹ He was keen to ensure impressive promotion of the profession especially as music therapy was not universally welcomed:

Both in residential and day care work, there is confusion over working conditions and pay scales (most Social Services departments still do not consider arts therapies qualifications to be 'relevant' in terms of pay) and concern that 'therapy' is in some circles seen as politically incorrect (eg. in parts of the disability rights movement, which has influence in council policy in many boroughs). Perhaps we need to address the fact that 'therapy,' to certain groups, equates with 'control' and has such negative connotations - and to be sure that we do not deserve it! There are also valid frustrations over bureaucracy and lack of reasonable funding - something many therapists will identify with!³²

I suggest that Gale is offering a pragmatic approach to the promotion of the music therapy profession in the UK. He is not suggesting that the fundamental values of music therapy are compromised or that the needs of the clients are neglected. If music therapy is misunderstood it will be detrimental to all concerned.

On the whole negotiations within the education sector were slow with little indication that a comprehensive and nationwide pay and career structure could be established for music therapists. There were, however, some indications that music therapy might become more firmly accepted. For example, by the beginning of the 1990s the Borough of Hillingdon was willing to pay for music therapy and it was hoped that, with more 'consistent, unified and clear policies within the Education Service many more children ... will benefit from music therapy in the future.'³³ Also there was more hope that music therapy might be able to be prescribed on a child's statutory Statement of Special Educational Needs. However, overall

³¹APMT AGM minutes (5.2.1994), p.19

³²APMT AGM minutes (11.2.1995), p.24

³³APMT AGM minutes (20.1.1990), p.8

there was little enthusiasm for supporting music therapists within education authorities and the majority of work was, and continues to be, undertaken on an *ad hoc* basis. Like Chris Gale, Angela Fenwick also recognised that music therapists were having actively to promote the profession:

... we all need to be able to 'sell ourselves.' This can only be done when we have a clear definition of what we are trying to "sell" and evidence to back up our statements. More and more, the notion of 'Evidence-Based Practice' is implying that we must 'prove' that what we are doing is sound, that it 'works' and that it is cost-effective. This is not always easy to quantify in disciplines such as ours. It would be nice to think that there were as many therapist in the Education Service involved in research as there appear to be within the NHS Trusts, for example.³⁴

The introduction of the internal market produced new demands, new policies and a fast changing vocabulary within the NHS to which the music therapy profession responded throughout the 1990s. In the previous chapter I noted that the music therapy profession in the 1980s recognised its need for trade union support. The APMT also made links with other paramedic professions and had begun to explore the possibility of applying to join the Council of Professions Supplementary to Medicine to gain State Registration. The need for support through connections with allied professions and, more particularly, the acceptance of the music therapy profession by the CPSM will now be explored, starting with a brief history of the development of the CPSM, before returning to the music therapy profession's response to developments within the NHS, such as the demand for accountability.

The Development of the Council for Professions Supplementary to Medicine

It is through control of the diagnostic relationship that the physician has maintained his pre-eminence in medical services. In Britain auxiliary health professions are defined by statute as 'professions supplementary to medicine.' This phrase indicates that physiotherapists, occupational therapists, chiropodists, dietitians, remedial gymnasts, etc., may carry out treatment only in respect of prior diagnosis by a doctor. As a result, the physicians have retained a position of authority vis-à-vis the patient, whilst subordinating emergent health groups to their own control and direction ... The proliferation of subordinate professional grades is, then, a possible consequence of specialisation where the generalists are sufficiently powerful to maintain control of the professional-client relationship. An appreciation of these power relations which exist between occupational groups would help to resolve

³⁴APMT AGM minutes (8.2.1997), p.28

some of the problems which sociologists have experienced in attempting to define the characteristics of a number of those groups which have been called the 'semi-professions' or 'quasi-', 'marginal' and 'limited' professions.³⁵

After the establishment of the NHS the Minister of Health set up a committee to investigate 'the supply and demand, training and qualifications of certain medical auxiliaries employed in the NHS.'³⁶ This committee made several recommendations including the statutory registration of medical auxiliaries. There were to be separate registers for each profession. These registers became the responsibility of one council which was made up of a number of professional committees. The CPSM was permitted to regulate twelve Boards.³⁷ The Boards were independent of the Council and also of each other with the Council offering collaboration and support between the public, the Boards and the Privy Council.

As well as the introduction of these registers, courses, training and qualifications for these professions were also reviewed. The Professionals Supplementary to Medicine Act was passed in 1960 with the establishment of the Council for Professions Supplementary to Medicine (CPSM). The Act protected the title *State Registered* which prevented unqualified professionals to practise within the NHS. The aim was to protect the public in three ways:

1. By regulating the initial qualification of registered professionals in the NHS.
2. By providing a strong moral authority for the responsible and orderly development of the professions regulated and hence encouraging proper practice through example and peer pressure.

³⁵Johnson, *Professions and Power* (1972), p.58

³⁶Ministry of Health, Department of Health for Scotland, *Medical Auxiliaries, Reports of the Committee* (Chairman, Dr V. Zachary Cope), HMSO, London, 1950 (Cmnd. 8188) cited in Ruth Levitt and Andrew Wall, *The Reorganized National Health Service*, 4th edition (London: Chapman and Hall, 1992), p.250

³⁷From 1960 the CPSM regulated the Boards for the following professions: Chiropodists, Dietitians, Medical Laboratory Technicians, Occupational Therapists, Physiotherapists, Remedial Gymnasts, Radiographers. In 1966 the Orthoptists joined and in 1988 the Remedial Gymnasts merged with the Physiotherapists. Prosthetists and Orthostists and Speech and Language Therapists all joined in the late 1990s. The Arts Therapies joined in 1997. The CPSM council consisted of 36 members; 12 registered members of the 12 professions that were appointed by their respective Boards; 13 members appointed by the Department of Health who were not members of the registered professions; 9 members appointed by the medical Royal Colleges and the General Medical Council and there were also 4 lay members that were appointed by the Privy Council (which included the Chair and one representative from Scotland and Wales and Northern Ireland.)

3. By providing a (last resort) mechanism for disqualifying professionals shown to be guilty of exceptional examples of misconduct.³⁸

The Music Therapy Profession's Application to the Council for Professions Supplementary to Medicine: The Reasons

When State Registration eventually comes about, it will in this world of market forces be if anything an even more vital safeguard to our profession than at first envisaged.³⁹

The APMT was keen for music therapy to be included under the umbrella of CPSM because it was seen that this would add weight and status to the profession, especially due to the opportunities that State Registration would offer. The CPSM offered a description of the relevance of State Registration thus:

State Registration is the definition of what is proper medical activity in a number of statutes. It implies high ethical standards, educational and professional excellence, and a higher expectation of duties of care than from unregistered practitioners. It also regulates interaction with other medical professions and with patients and is the instrument of self-governance independent of educational, employment, governmental, or professional interests.⁴⁰

Wigram had explored the possibility of coming under CPSM during the 1980s when the occupational therapy profession was wanting to take over management of the arts therapies. However, he felt that the music therapy profession at that time 'didn't have a strong enough body of knowledge, or a strong enough profession to withstand close scrutiny and substantial evidence for this,'⁴¹ and so negotiations were halted until the beginning of the 1990s. During the 1990 APMT AGM there was a discussion on the advantages of registration. The Chair, Mark Jordan stated:

³⁸J. M. Consulting Ltd., *The Regulation of Health Professions: Report of a review of the Professions Supplementary to Medicine Act (1960) with recommendations for new legislation* (1996), p.18. Document held within APMT archives. File B:1

³⁹APMT AGM minutes (10.2.1996), p.32

⁴⁰Council for Professions Supplementary to Medicine, *General Information about the Organisation and the Role and Requirements of the Chairman*, (Source unknown, undated)

⁴¹Wigram, Tony, unpublished letter written to Rachel Darnley-Smith (10.4.1990), p.1 Document held within the APMT archives. File BL:1

At present people can qualify as music therapists, but having done so there is no way of knowing that they are maintaining satisfactory standards of practice. The fact that a therapist is a full member of the APMT should count for something in this respect, in that it is known they have agreed to uphold the Code of Professional Ethics and Discipline. In addition, they have full access to the latest information on developments in the profession; they have also been alerted to the importance of supervision and the need for professional indemnity through a union or insurance. A system of registration would enable a member to demonstrate this to employers and to the public by putting certain letters after their name. The use of such standard letters for all qualified registered music therapists would also be less confusing than the various different titles that the courses provide, particularly when in the future we have many more recognised courses. The aim would be to help clarify the status of the profession as a whole ... Both the National and American Associations for Music Therapy in the USA have such systems.⁴²

Tony Wigram also offered various reasons why State Registration would be beneficial both to the music therapy profession as a whole and to each individual practitioner:

The process by which this happens involves a close, hard look at our profession, its present status and whether it meets the guidelines. Subsequently, a successful application will require a Statutory Instrument (Act of Parliament or Extension to an Act), and it will need to go through both Houses. The benefits to us if we are successful will be considerable:

1. Together with art therapy, we will have compatibility as a State Registered Profession with other professions supplementary to medicine.
2. We will have a special Board set up for us by the CPSM.
3. Our status and professional acceptability will be greatly enhanced in both the medical, education and social services.
4. Lay people and fellow professionals will have much greater confidence in a profession that is regulated by an Act of Parliament.
5. In the next 2 or 3 years with the changes that are occurring in the Health Service, it will be greatly to our advantage to be a State Registered Profession.
6. Members will be entitled to put the letters SRMTh (State Registered Music Therapist) after their names (provided this is the abbreviation we choose) [In fact the abbreviation used was SRAsT(M), State Registered Arts Therapist (Music)]
7. It will undoubtedly improve the position of many students who are seeking grants for the training required to enter the profession.

⁴²APMT AGM minutes (20.1.1990), pp.19-20. Despite Jordon's comments it needs to be noted that the legal right to practice was not dependent on membership of the APMT. The APMT has always been a voluntary professional organisation. Although it has never had the legal ability to regulate or discipline music therapists in the UK it has been regarded by the DoH as a source of expertise which can offer specialist knowledge to support decisions made by the government regarding the practice of music therapy.

8. It will certainly improve the position of music therapists attempting to set up new work.
9. Overall, it will enhance the status and position of music therapy in Great Britain.⁴³

The music therapy profession would be joining physiotherapists, occupational therapists, chiropodists, dietitians, medical laboratory officers, radiographers and orthoptists, all of which were already State Registered and regulated by The Professionals Supplementary to Medicine Act, 1960. This move would help to implement a disciplinary procedure, a registration procedure where all qualified therapists are registered and agreement within the profession on standards required for the training of music therapists.⁴⁴

There were other benefits to being included under the CPSM umbrella. State Registration is seen as a form of validation which is independent from both the government and the professionals themselves. This would offer both the professionals and the service users protection because only those who had qualified could hold the title State Registered art/music/drama therapist. As the CPSM suggested:

It is foreseeable that medical insurance companies could take a less generous view of the professions if they remain unregulated outside the NHS. It is also possible that financially constrained NHS and NHS Trust authorities might seek to distance themselves from professions with whom they enjoy no formal statutory links ... As a development of this point, [arts therapists] often work with registered members of a variety of other professions ... [and] it is potentially anomalous for some team members to be state registered and other not.⁴⁵

State Registration would not only help those music therapists working in the NHS but would also impact on the working conditions of all practitioners including those working in private practice. Freidson's theory emphasised that practitioners with more autonomy (such as freelancers or those working in private practice) had a greater duty to the public to demonstrate a sense of professional responsibility since they were less accountable to

⁴³APMT AGM minutes (19.1.1991), pp.12-13

⁴⁴Ibid., p.12

⁴⁵Council for Professions Supplementary to Medicine, *Particular Advantages to the Public of State Registration for Arts Therapists* (12.1.1992). Document held within APMT archives. File BL:1, pp.3-4

employers or organisations. Similarly Larson noted that two of the goals within the process of professionalisation was to gain respectability and to make links with allied professionals. Coming under the umbrella of the CPSM helped the music therapy profession to attain these goals.

I have already emphasised that Larson and Freidson's theories were based on the premise that professions and governments exist separately, whilst Johnson *et al.* considered that the professions were a subsection of government. Although the CPSM can, on one level be described as an independent body, according to Johnson *et al.* this is not a realistic view of any kind of regulating force. Johnson wrote:

... the 'neutrality' of professional expertise, where it exists, is itself an outcome of a political process rather than the product of some inherent essence, such as esoteric knowledge. Once we see institutionalized expertise as an aspect of governmentality then it is possible to recognize that professionalization begins not only with the adoption of occupational strategies, but also with the formation of government programmes and objectives.⁴⁶

On the one hand it is possible to see that the music therapy profession recognised for itself the advantages in applying to the CPSM for support. However, Johnson's theory suggests that the music therapy profession and the CPSM did not have any real autonomous choice about these developments. According to this theory it is the government that has the power to support or deny an occupation because '... expertise, as it became increasingly institutionalized in its professional form, became part of the process of governing.'⁴⁷ Whilst this theory describes the symbiotic relationship between government and professions it is, nonetheless, necessary for all parties to be perceived as separate from each other. As Johnson wrote:

... not only that the independence of the professions depends on the interventions of the state, but that the state is dependent on the independence of the professions in securing the capacity to govern as well as legitimating its governance.⁴⁸

⁴⁶Johnson, 'Governmentality and the institutionalization of expertise' (1995), p.18

⁴⁷Ibid., p.9

⁴⁸Ibid., p.16

This theory raises the question of the extent to which the music therapy profession had the capacity to make autonomous decisions about its application to the CPSM for support. Although the APMT was not overtly forced to make its application Wigram offered compelling reasons why the profession needed to take this next developmental step.

The Application Process for the Council for Professions Supplementary to Medicine

The CPSM listed two aspects it deemed necessary before it would make a recommendation to the Privy Council for an extension of the Professions Supplementary to Medicine Act 1960:

It has been agreed that the only effective criteria in the Act were those of being a profession and one being 'supplementary to medicine' as judged by the Council in consultation with the existing Boards.⁴⁹

Although the CPSM did not specifically explain what a profession is or what is meant by being 'supplementary to medicine' it did offer a list of guidelines for organisations hoping to apply to the CPSM. This list can be seen to mirror Millerson's list of traits that can be attributed to a profession and it is worth citing in full as it has a crucial implication for this thesis:

1. that the profession has reached maturity and, for example, has an established and recognised governing body;
2. that it is based on a systematic body of knowledge, which may or may not be wholly scientific in character, which is compatible with the body of knowledge for the time being attributed to and acknowledged to be the basis of contemporary medical practice;
3. that the profession has a mutually accepted relationship with those organisations at the time taken to represent practitioners of contemporary medical practice; and that such medical organisations are willing to nominate medical practitioners who are prepared to serve on a board for the new profession;
4. that the profession has a recognised course of training over a substantial period;
5. that its examinations are adequate and properly conducted, with particular reference to the appointment of recognised external examiners or assessors, for example, by universities or the Royal Colleges;

⁴⁹Council for Professions Supplementary to Medicine, *Extension of the Act to Additional Professions S10* (July 1977). Document held within APMT archives. File BL:1, p.1

6. that a minimum education standard is enforced for all entrants although special provision may be made for the acceptance of mature students with relevant experience;
7. the applicant organisation should have an appropriate and acceptable code of conduct regulating relationships with patients and members of other professions to be able to satisfy the Council that the members of the profession are willing or need to be governed by such a code.⁵⁰

This list has a particular emphasis on training and the establishment of a governing body which has produced a clear code of conduct and these have been seen to be two main elements of what constitutes a profession according to a variety of sociological studies.

Both Tony Wigram and the art therapist Diane Waller discussed State Registration with the CPSM and Wigram prepared an application based on these guidelines for an extension to the Act on behalf of the music therapy profession. This application provided evidence required by these guidelines and offered information on seven points. To summarise, Wigram noted that the therapeutic use of music had been acknowledged for centuries and that the music therapy profession was based on this background. He emphasised the rigorous theoretical training that was involved, the efficiency of the APMT as a governing body including its production of a formal code of professional ethics and the recognition of music therapy by established professions. Wigram's list closely followed the guidelines set out by the CPSM and thus also links closely with the trait theorists such as Millerson. To demonstrate these similarities the lists by Millerson and Wigram are cited together below:

⁵⁰Ibid., p.2

| Millerson | Wigram |
|--|--|
| The professional must demonstrate competence by passing a test | Post-graduate training in music therapy |
| The profession is organized | Governing body of music therapy |
| A profession involves a skill based on theoretical knowledge | Theoretical basis for the practice of music therapy |
| The skill requires training and education | Post-graduate training in music therapy |
| Integrity is maintained by adherence to a code of conduct | Code of Professional Ethics |
| The service is for the public good. ⁵¹ | Clinical material and research material in support of the application. Present status and maturity of the music therapy profession Relationship with the medical profession. ⁵² |

In order to support the application Wigram wrote letters to various professions allied to medicine for support and to help fulfil the second requirement by the CPSM, namely that the applicant should be one *supplementary to medicine*. He received numerous replies offering support⁵³ with the exception of the British Psychological Society which was concerned by the arts therapies' use of psychotherapeutic techniques. The CPSM responded to this concern by pointing out that the arts therapies were attending to the concerns of inappropriate practice by joining the CPSM and that this should be applauded.⁵⁴

Wigram stated that it was important that the application document identified music therapy as a complementary treatment and not an alternative treatment and thus demonstrate that music therapy 'collaborates with and is compatible with contemporary medical practice

⁵¹Millerson, *The Qualifying Associations. A Study in Professionalization* (1964), p.4

⁵²APMT AGM minutes (19.1.1991), pp.13-14

⁵³Various Societies were supportive of the art and music therapy's application for State Registration. See letters by Anderton, J. L. (5.4.1991); Beattie, Alistair D. (19.3.1991); Ralph, Colin (22.4.1991); Richards, Sheelagh (19.10.1991); Towers, Peter (30.4.1991); Gath, Ann (19.2.1991); Hancock, Christine (6.2.1991); Field, Ian (11.6.1991), to R. Pickis regarding the response to the 'Application from the Professions of art and music therapy for State Registration status.' Documents held within APMT archives. File BL:1

⁵⁴See Lindsay, Geoff, letters to R. Pickis regarding the response to the 'Application from the Professions of art and music therapy for State Registration status,' by The British Psychological Society (5.2.1991), (20.3.1991) and (21.10.1991), File BL:1

[and] ... is an additional and unique therapeutic intervention with proven effect and value.⁵⁵ Proctor argued that the music therapy profession has connected itself too closely to the biomedical profession. He stated that the values underpinning these two professions are not compatible. Furthermore he is concerned that the music therapy profession has aligned itself to the biomedical profession only to secure its status as a profession and this is not in the interests of the clients.⁵⁶ I suggest that, at the point in time when the APMT was making this application, there was overwhelming evidence that the music therapy profession would benefit from joining the CPSM. Given these circumstances, I suggest that the music therapy profession has had little, if any, autonomy with which to have any choice in this development. I argue that the music therapy profession found the evidence for collaboration with the medical profession overwhelming.

Having presented the case for music therapy to come under the umbrella of the CPSM, the CPSM stated that it was willing to accept the application and was:

- * ... only considering art and music therapy for State Registration.
- * ... propos[ing] a Joint Board.
- * ... want[ing] evidence of support from the membership of the APMT.
- * ... suggest[ing] reciprocal observers on the boards of other professions.
- * ... want[ing] the application to move forward quickly and the whole process to be completed by the end of 1991 (Parliamentary time permitting).
- * ... put[ting] the information out for consultation with professional bodies, and would like to make visits to see music therapy training and music therapy in practice.⁵⁷

Whilst both the art and music therapy professions submitted applications to the CPSM in 1990 the drama therapy profession submitted a year later and the CPSM agreed that the Privy Council should be approached to establish a Federal Board for all three of these arts therapies.⁵⁸ The APMT was advised that the process to gain State Registration would be

⁵⁵APMT AGM minutes (19.1.1991), p.13

⁵⁶See Proctor, 'Playing Politics: Community Music Therapy and the Therapeutic Redistribution of Music Capital for Mental Health' (2004)

⁵⁷APMT AGM minutes (19.1.1991), p.14

⁵⁸The arts therapies were to come under one umbrella, namely the Arts Therapists Board, which consisted of three separate professions - music, art and drama therapies. These three professions were joined together because it was perceived to be more economical to combine three small professions with relatively few members in comparison to the larger professions such as the Chartered Society of

long and drawn out with the Privy Council having the final say in the matter after it had consulted various medical bodies such as the General Medical Council, the British Medical Council, the British Psychological Council and the Royal College of Psychiatrists.⁵⁹ Ann Sloboda wrote a clear summary of the events surrounding the application for State Registration including a quotation from the CPSM which stated:

... the relevant minister at the DoH (Baroness Cumberledge) has given the Department's support to the petition to the Privy Council for an Arts Therapies Board. This means that the petition has become - in the largest sense - part of the Government's legislative programme for which it now takes responsibility and that it will speak in favour of it at the relevant fora.⁶⁰

During 1992-3 the Registrar of the CPSM prepared to submit an application to the Privy Council from the Arts Therapists regarding State Registration. Peter Burley, the Deputy Registrar of the CPSM, wrote a letter on 20th January 1993 regarding the application which was read out at the APMT AGM in February 1993. It set out the processes which had occurred emphasising how long the process would take. The Privy Council also wanted to investigate the issue for itself, asking for advice from the medical profession as well as other government departments.⁶¹ A subsequent letter was written by the CPSM to the Privy Council on 8th October 1993 recommending that the Professions Supplementary to Medicine Act, 1960 was extended to include the art, music and drama therapies and they eventually joined on 26th March 1997.

John Strange stated that State Registration would offer 'increased autonomy of the individual professional associations such as ours in matters peculiar to those professions, greater solidarity over common causes and reduced domination by the Royal Colleges.'⁶² I suggest that this comment offered an overly simplistic view of the future of the music therapy profession. State Registration eventually began on 1st June 1999 and the APMT

Physiotherapy.

⁵⁹APMT AGM minutes (6.2.1993), pp.8-9

⁶⁰APMT AGM minutes (5.2.1994), p.11

⁶¹Ibid., p.11 and APMT AGM minutes (6.2.1993), pp.8-9

⁶²APMT AGM minutes (10.2.1996), p.32

noted that a number of music therapists re-joined the APMT at the point when State Registration came into effect. Chris Gale described the situation thus:

The purpose of State Registration is the protection of the public, through regulating standards of training, and investigating where there are questions over conduct. These functions have therefore passed from the Professional Associations to the Board, although the Associations are very much involved through inclusion in committees which carry out much of the detailed work ... this registration is compulsory in the NHS and Social Services, where regular checks are likely. Board meetings are attended by nine representative members (three per discipline), appointed members and observers.⁶³

This quotation explains that the CPSM/HPC would be regulating the code of conduct and standards of training for arts therapies. Although the APMT has been involved with offering specialist information and knowledge to the CPSM/HPC to aid the regulation and monitoring for State Registration the CPSM/HPC is not obliged to act on this advice. Theoretically it can choose not to accept the recommendations made by music therapists. For example, a training course could be approved by the CPSM/HPC but it does not have to work to the standards recommended by the APMT. Therefore music therapists could qualify and become State Registered without any reference to the APMT. However, after the CPSM/HPC Federal Board was established (with representatives from the three arts therapy professions) the Joint Quality Assurance Committee (JQAC) was created to approve the training courses and it had specialist input from members of the professional bodies including the APMT.

Reviewing the Council for Professions Supplementary to Medicine

The prime function of the CPSM was always the protection of the public (rather than for the benefit of the professions themselves) and in its final annual report the CPSM admitted that it had been too powerless to give the public 'the full and proper protection it deserve[d].' A review of the CPSM in 1996 by J. M. Consulting Ltd. felt that there were inadequate disciplinary procedures and Continuing Professional Development programmes for those professions that came under the umbrella of the CPSM. The four key areas which this review felt could be clarified to offer better protection for the public were initial

⁶³APMT AGM minutes (4.3.2000)

qualification/registration, continuing competence/professional development, standards and ethics, and discipline. This Review stated:

Real tensions are building up in the system because of the conflict between the need for integrated working and the professions' insistence on independence and separatism. The current legislation reinforces the separateness.⁶⁴

The review also noted that, since the founding of the CPSM in the 1960s, 'attitudes, knowledge and expectations of patients, consumer organisations and tax-payers [had] changed significantly.'⁶⁵ It explained that the structure of the CPSM was not particularly efficient and suggested that the professions could work more closely together because it felt that there were sufficient cross-professional issues to warrant more intense inter-professional collaboration. The document recognised that this would decrease the autonomy of the individual professions. Although each profession had its own set of skills and knowledge, training and education which would need to be considered independently, it was felt that issues regarding ethics and codes of conduct could be dealt with in a more cross-professional manner.

The Allied Health Professions Forum were unhappy with this proposal because it felt there were too many differences between the various professions that came under the CPSM umbrella to warrant the kind of inter-professional collaboration suggested in the J. M. Consulting document. It stated that '[a]ccidents of history have brought [these professions] ... together under a single State Registration System. It is true that many of the professions work together in professional teams to deliver effective care, but that does not reduce their unique professional discipline any more than working with doctors makes everyone a doctor.'⁶⁶ A document entitled *Extended Scope Practitioner* explained:

⁶⁴J. M. Consulting Ltd., *The Regulation of Health Professions: Report of a review of the Professions Supplementary to Medicine Act (1960) with recommendations for new legislation* (1996), p.49

⁶⁵Ibid., p21

⁶⁶Allied Health Professions Forum, *Allied Health Professions Response to the Government Consultation on 'Modernising Regulation - The New Health Professions Council'* (1.11.2000), p.14. Document held within APMT archives. File R:1

It is important to recognise that some postholders - even some professions - may be reluctant to relinquish non-specialist aspects of their role for fear of becoming de-skilled in important areas which they may need to exercise in the future. It is therefore useful to find ways of ensuring that postholders do not get into a career cul-de-sac.⁶⁷

Donald Schön suggested that the professions were being forced to cope with 'complexity, uncertainty, instability ... and value-conflict'⁶⁸ and the speed with which the government was creating policy changes for the NHS created a sense of vulnerability for the medical professions. The White paper, *The New NHS*, published in 1997, stated that there was a 'third way' of running the NHS - a system based on partnership and driven by performance.⁶⁹ The government felt that the internal markets had encouraged unproductive competitiveness which it proposed to replace with greater cooperation between different sections of the NHS. It was suggested that enabling transparent and open communication to flow through the NHS which would be open to public scrutiny would help to increase public confidence.

The government aimed to improve services through the introduction of Clinical Governance and the National Institute for Clinical Effectiveness (NICE) in 1999. NICE aims to produce and disseminate 'clinical guidelines based on relevant evidence of clinical and cost-effectiveness [and] associated clinical audit methodologies and information on good practice in clinical audit.'⁷⁰ Some music therapists in the UK have engaged with these issues by considering its ability to construct appropriate research projects.⁷¹

⁶⁷Association of Professional Music Therapists archives., *Extended Scope Practitioner* (Source unknown: undated). Document held within APMT archives. File BL:1

⁶⁸Schön, *The Reflective Practitioner: How Professionals Think in Action* (1991), p.39

⁶⁹National Health Service, *The New NHS. Modern, Dependable* (White Paper: 8.12.1997), section 2.2

⁷⁰Ibid., section 7.11

⁷¹See for example, Wigram, Tony, 'Indications in Music Therapy: evidence from assessment that can identify the expectations of music therapy as a treatment for Autistic Spectrum Disorder (ASD); meeting the challenge of Evidence Based Practice,' in *British Journal of Music Therapy* (Vol. 16 (1): 2002), pp.11-28 and Ansdell, Gary, Pavlicevic, Mercédès, and Proctor, Simon, *Presenting the Evidence: A Guide for Music Therapists Responding to the Demands of Clinical Effectiveness and Evidence-Based Practice* (London: Research Department, Nordoff-Robbins Music Therapy Centre, 2004)

The introduction of NICE and the findings of the J. M. Consulting Ltd. document emphasised the desire for clearer accountability as well as closer, non-competitive collaboration between professions.⁷² The music therapy profession in the UK had already made strong links with the other arts therapies. Once the arts therapies together had linked with the CPSM they automatically became associated with the other professions which came under the auspices of the CPSM. One hand there were concerns that attempts to create inter-professional collaboration between this disparate group of professions might not appreciate the unique needs of each different profession. For example, some members of the arts therapies were concerned that there might be moves towards a generic arts therapies profession. On the other hand the moves away from the twelve separate Boards of the CPSM towards a more streamlined, inter-professional collaborative HPC meant that certain elements of work were not duplicated twelve times but coordinated more effectively.

Larson had noted that inter-professional collaboration was one of the later stages in the process of professionalisation and this issue will be investigated more fully after a exploration of the manner in which the music therapy profession in the UK has coped with the demands for accountability.

Accountability - How the Music Therapy Profession in the UK Coped

A profession that carries out the work of a state system, like the NHS, means that both parties must 'find ways of accommodating the frustrations and resentments of both sides in the partnership, and to devise organizational strategies for containing conflicting interests.'⁷³

With regard to professional accountability, the review by J. M. Consulting Ltd. identified that the role of the regulatory body (ie. CPSM/HPC) was primarily to protect the public whilst the role of the professional body was primarily to protect the professionals. The report offered a cautionary statement:

⁷²The CPSM became the Health Professions Council on 1.4.2002. Bishton stated that 'Its first year will be spent on consultation with the professions and other bodies to determine standards for registration, titles to be protected and the function and composition of Professional Advisory Panels (PAPs).' APMT AGM minutes (16.3.2002), p.3

⁷³Klein, R., 'The state and the profession: the politics of the double bed,' in *British Medical Journal* (3.10.1990), p.700 cited in Light, 'Countervailing powers: a framework for professions in transition' (1995), p.31

... the professions need to recognise that it is a privilege to be allowed to self-govern: that the alternatives are less attractive, and that it is therefore in their interests to contribute to the process of self-regulation.⁷⁴

The most obvious alternative to self-regulation to which this report alludes is transparent auditing undertaken by those outside the profession. Michael Eraut wrote:

Logically, the greater one's autonomy, the greater one's responsibility; and therefore the greater one's accountability. But for social and historical reasons that is not how it is perceived. Accountability has been presented to professional workers more as an external control mechanism than as a strengthening of their moral and professional obligations: and hence as a threat to autonomy rather than a consequence of it.⁷⁵

The perception of audit being imposed by an external authority links with Freidson's theory of professions' perpetual struggle for autonomy from the government. Schön suggested that the professions might consider accepting and working with external audit proceedings rather than fighting this imposition:

[it is possible] to show how the professional-client contract may be transformed within a framework of accountability, when the professional is able to function as a reflective practitioner ... the professional recognizes that his (sic) technical expertise is embedded in a context of meanings. He attributes to his clients, as well as to himself, a capacity to mean, know and plan.⁷⁶

The J. M. Consulting Ltd. report explored the need for the professions and the government to balance and negotiate their roles of responsibility for professional regulation:

when purely voluntary self-regulation is considered insufficient, then professional self-government on a statutory basis is used. It is considered an unwritten contract, a bargain between profession and State, where the professions undertake to maintain a *high* professional standard of education and conduct, *without cost to the State*, in

⁷⁴J. M. Consulting Ltd., *The Regulation of Health Professions: Report of a review of the Professions Supplementary to Medicine Act (1960) with recommendations for new legislation* (1996), p.55 section 5.22

⁷⁵Eraut, Michael, *Developing Professional Knowledge and Competence* (London: The Falmer Press, 1994), pp.224-225

⁷⁶Schön, *The Reflective Practitioner. How Professionals Think in Action* (1991), p.295

return for the right to manage some [of] its own affairs, and in the case of dentistry, legal monopoly of practice.⁷⁷ (*italics in the original*)

This quotation suggests that the professions and the government are separate and yet Terry Johnson, Gerry Larkin and Mike Saks argue that 'professionalization and state formation have been different aspects, or profiles, of a single social phenomenon in the modern world.'⁷⁸ According to this definition the self-regulation of the professions is not independent from the activity of the government and Johnson suggested that the whole issue of accountability is based on the *perception* of independence:

... not only that the independence of the professions depends on the interventions of the state, but that the state is dependent on the independence of the professions in securing the capacity to govern as well as legitimating its governance.⁷⁹

The APMT and the music therapy training courses were pleased to receive external validation of the training courses. At the same time the government has been keen to demonstrate its authority over the music therapy profession by making demands for clearer accountability. These activities have helped both parties to be perceived to be working independently. Wigram wrote clearly about the importance of accountability and the relationship between the music therapy profession in the UK and the medical profession:

I [Wigram] made a very clear statement that we [the music therapy profession] saw ourselves as accountable to medical practitioners for the treatment of clients for whom the medical practitioner had overall responsibility as the Responsible Medical Officer (RMO). I think there was a certain element inside the profession, especially in people who were working in private practice, who felt that they did actually function autonomously - which in their case was quite right. But the point was, our profession in most cases was sitting inside health service situations in which doctors are accountable, by law, for everything that happens to their patients. And the issue was more about if we were asking for inclusion within the organisation called Professions Supplementary to Medicine (CPSM) as an independent profession that didn't consider itself as supplementary to medicine, what was our relationship to the

⁷⁷J. M. Consulting Ltd., *The Regulation of Health Professions: Report of a review of the Professions Supplementary to Medicine Act (1960) with recommendations for new legislation* (1996), p.55 section 5.21

⁷⁸Johnson, 'Governmentality and the Institutionalization of Expertise' (1995), p.13

⁷⁹*Ibid.*, p.16

medical profession? So I said that we did not consider ourselves to be an alternative treatment, but a treatment that was complementary to current medical practice.⁸⁰

The arts therapies professions in the UK might argue that self-reflection has always been a significant aspect of the work but it would be naive to think that arts therapists are content with the growing demand for accountability. However, the music therapy profession in the UK has attempted to engage with this issue by instigating a supervision scheme, promoting continuing professional development and examining new methods for research projects.

Supervision

In 1990 two music therapists, Ann Sloboda and Helen Loth, worked together to produce a post-graduate supervision scheme. Juliette Alvin had wanted only highly skilled musicians to be accepted on to the training courses and she wanted the training itself to be of the highest standard. Despite this demand for high standards the courses (until the middle of the 1990s) were, nonetheless, only one year long. The introduction of a supervision scheme helped to prolong the training process. Not only did this expand the training it also helped to give the perception that the music therapy profession demanded highly standards from practitioners. It was committed to offering longer training without having, at that stage, to increase the length of the courses. The length of training and the perception of a committed professional organisation helped the pay and conditions negotiations between the APMT and Whitley Council. The reasons for introducing this supervision support could have been based on a desire to be *perceived* to be a trustworthy profession rather than an *actual* desire to improve the music therapy service to clients. I suggest that, regardless of the primary motivation behind the introduction of the supervision scheme, the professionals, the clients, the employers and the APMT all have benefited.

It had been agreed at the 1989 APMT AGM that the supervision scheme would be set up for music therapists for the first year after qualifying and that a list of APMT registered supervisors would be available to them and to any other APMT member. Potential supervisors were interviewed by a panel 'so that the APMT had a way to set and keep up

⁸⁰Wigram, 'Historical Perspectives Interview Series' (2000), p.10

a good standard of practice.⁸¹ Candidates needed to have qualified for three or more years and the interviewing panel consisted of a psychotherapist, an art therapist and three music therapists (one from each training course).

By 1993 there were a total of 22 APMT registered supervisors and the members who used the scheme were enthusiastic about the scheme.⁸² It was proposed that the mandatory supervision for newly qualified music therapists should consist of 32 hours of supervision to be undertaken with an APMT registered supervisor. However, the supervision scheme has been dogged by complex practical and ethical issues and it has received much criticism from members, particularly those who live in remote parts of the country, who do not have access to APMT registered supervisors.⁸³

In order to attempt to reinforce mandatory supervision for newly qualified music therapists the APMT needed to add a level prior to full membership. It was at the 1994 AGM that the category of Provisional Member was accepted and brought into effect in 1996. Prior to State Registration the APMT stated that a music therapist had not fully completed their training until they had completed these 32 hours of supervision as well as successfully completing one of the validated courses. However, since the CPSM/HPC took on responsibility of State Registration the APMT has lost the authority to impose mandatory supervision. Overall the APMT has become a much less powerful influence over the music therapy profession in the UK since the CPSM/HPC took responsibility for State Registration.

Receiving supervision is seen as an important part of the requirement for Continuing Professional Development (CPD) as stated by the CPSM/HPC. The APMT recognised that

⁸¹APMT AGM minutes (20.1.1990), p.18

⁸²For a comprehensive description of the criteria to be met to become a supervisor, see APMT AGM minutes (6.2.1993), pp.17-18

⁸³The following motion was carried at the APMT AGM (6.2.1993), p.20:
'Part 1: The executive Committee of the APMT proposes that a system of mandatory casework supervision should be implemented whereby newly qualified therapists would be required to have 32 hours supervision. The minimum number of clinical contact hours for the 32 hours supervision could be 320 hours, taken over a minimum of one year.
Part 2: Unless otherwise agreed with the APMT core panel, this supervision should be with a music therapist from the APMT approved supervisors list.'

CPD would become a mandatory requirement for State Registration and developed a project to enable music therapists to consider further training.

Continuing Professional Development

The introduction of the internal market, which created tensions and restricted autonomy for the medical professions, can be seen as one of the main catalysts for the development of CPD. Alaszewski identified four key justifications for the introduction of internal markets:

- * the establishment or improvement of market mechanisms and the increase of financial control;
- * the reduction in restrictive practices to 'create a level playing field;'
- * increases in the power and status of consumers, especially by increasing the flow of information to potential consumers;
- * inspection of the quality of services.⁸⁴

The last two points are most pertinent to the introduction of audit processes and Continuing Professional Development. Dissemination of information increases the power of patients and reduces the autonomy of the medical professionals and, as such, alters the relationship between the state, the professionals and the public. Michael Eraut stated that it is vital for each party to be involved in supporting each other to develop new skills for the dissemination of information. He wrote that, 'unless the professions renegotiate their role in society with the laity, they will be destroyed by the current growth of pressures upon them.'⁸⁵ Edgar Schein also recognised that there have been some fundamental changes within society and within the work environment which have made an impact on professional autonomy:

It is quite clear that as the work setting of professionals shifts towards employment in large organizations, professional autonomy is eroded and new concepts of responsibility to clients must be developed. This trend may or may not be desirable from the point of view of either the professional or the clients, yet because of technological, economic, and social factors, the trend exists.⁸⁶

⁸⁴Alaszewski, 'Restructuring health and welfare professions in the United Kingdom. The Impact of internal markets on the medical, nursing and social work professions' (1995), p.59

⁸⁵Eraut, *Developing Professional Knowledge and Competence* (1994), p.237

⁸⁶Schein, Edgar, *Professional Education. Some New Directions* (New York: McGraw-Hill,

Hannes Siegrist suggested that there are a number of different parties involved with the development of any profession including the state or government, members of the profession, employers, managers, professional bodies or guilds, the clients, client organisations, the professional educators and the media.⁸⁷ Each party involved will have different needs and desires from any audit or monitoring process: clients are wanting reassurance of quality of service, employers and the state demand value for money, whilst the professionals themselves are hoping to gain job satisfaction.⁸⁸

Continuing Professional Development is one response to the issue of accountability and it is worth offering two definitions of CPD as well as exploring the relevance of this form of accountability. The first definition is by Sandra Clyne:

The systematic maintenance, improvement and broadening of knowledge and skill and the development of personal qualities necessary for the execution of professional and technical duties throughout the practitioner's working life.⁸⁹

Cyril Houle offered a second definition:

The way in which professionals try, throughout their active lives of service, to refresh their own knowledge and ability and build a sense of collective responsibility to society.⁹⁰

This second definition highlights the moral obligations that professions have to the society which they aim to serve. Any kind of audit process, such as CPD, needs to be achieved in a manner which is open to scrutiny. Furthermore, Nigel Hughes suggests that one of the important aspects of accountability is that the profession or professional needs to be *seen*

1972), p.20

⁸⁷See Siegrist, Hannes, 'The Professions, State and Government in Theory and History,' in *Governments and Professional Education*, ed. Tony Becher (Buckingham: Society for Research into Higher Education and Open University Press, 1994), pp.3-20

⁸⁸See Schein, *Professional Education. Some New Directions* 1972, p.18

⁸⁹Clyne, Sandra, 'Introduction,' in *Continuing Professional Development, Perspectives on CPD in Practice*, ed. Clyne, Sandra (London: Kogan Page, 1995), p.15

⁹⁰Houle, Cyril., *Continuing Learning in the Professions* (San Francisco: Jossey-Bass, 1980), p.2, cited in Clyne, 'Introduction,' in *Continuing Professional Development, Perspectives on CPD in Practice*, ed. Sandra Clyne (London: Kogan Page, 1995), p.15

to be improving the service through audit, monitoring, continuing professional development, reviewing and assessment. This will encourage those outside the profession to trust both the individual practitioners and the professional body as a whole.

As already noted, the introduction of the internal markets and the subsequent White Paper, *The New NHS*, encouraged clearer patient-professional partnership. It also demanded more efficient communication channels to disseminate more information to help consumers or clients to make informed choices. CPD is a way of encouraging professionals to update their knowledge, learn new skills and improve their personal effectiveness. If professionals are seen to be updating their knowledge and skills the consumers can be assured that professional standards are attempting to be maintained. According to Eraut the participation of CPD by individual practitioners involves:

- a moral commitment to serve the interest of clients;
- a professional obligation to self-monitor and to periodically review the effectiveness of one's practice;
- a professional obligation to expand one's repertoire, to reflect on one's experience and to develop one's expertise;
- an obligation that is professional as well as contractual to contribute to the quality of one's organization; and
- an obligation to reflect upon and contribute to discussions about the changing role of one's profession in wider society.⁹¹

Eraut believed that it is the responsibility of both the individual practitioner and the professional bodies to be engaged in CPD to ensure that standards are maintained. Each party engaged in CPD needs to support the process because 'it is difficult for professionals to sustain their accountability to clients or to the continuing development of their knowledge base unless their employing organization has some genuine commitment to quality.'⁹²

Response to the Introduction of Continuing Professional Development

⁹¹Eraut, *Developing Professional Knowledge and Competence* (1994), p.236

⁹²*Ibid.*, p.237

Mike Dent explained that the medical profession were reluctant to engage in the process of accountability⁹³ and Charles Shaw stated that '[m]any doctors view audit not with delight but with resignation and the hope that, if it is inevitable, something good will come of it. Perhaps it is the price we pay for being in the profession with the fastest rate of change.'⁹⁴

If audit, monitoring, reviewing or CPD are to be accepted by the professionals, each procedure needs to be carefully introduced and implemented. Clare Rapkins commented on the advantages and disadvantages of different approaches to CPD projects. Her research noted that old and established full professions (such as medicine) have a different approach to CPD than the new and developing semi-professions. The former use a 'sanctions model' in which CPD is mandatory whilst the latter use a 'benefits model' which is based on voluntary participation with emphasis being placed on the benefits and rewards of participation.⁹⁵ The 'benefits model' focuses on self-monitoring and the motivation to learn new skills to gain work rewards. In the 'sanctions model' the professional bodies monitor the CPD participation with emphasis on the number of hours required to satisfactorily complete the process. Rapkins research concludes that the 'benefits model' is more successful primarily because it is based on self-motivation. She stated that successful CPD practice is based on:

- a) good communication between professional bodies
- b) a continuum of education between pre- and post-qualifications
- c) clear policy statements
- d) clear aims for CPD
- e) planned and systematic approach to CPD
- f) a range of CPD activities
- g) employers recognising the relevance and importance of CPD
- h) CPD provision only available through professional bodies
- i) accessible to all (ie. employers and professionals) and inexpensive

⁹³See Dent, Mike, 'Doctors, Peer Review and Quality Assurance,' in *Health Professions and the State in Europe*, eds. Terry Johnson, Gerry Larkin and Mike Saks (London: Routledge, 1995), pp.86-102

⁹⁴Shaw, Charles D., 'Looking forward to audit,' in *Audit in Action*, ed. Richard Smith (London: British Medical Journal, 1992), p.34

⁹⁵See Rapkins, Clare, 'Best Practice for Continuing Professional Development: Professional Bodies Facing the Challenge,' in *Continuing Professional Development. Issues in design and delivery*, ed. Ian Woodward (London: Cassell, 1996), pp.216-221

- j) emphasis on links between professionals, employers, providers and professional bodies
- k) monitoring and evaluation only achieved when necessary
- l) emphasis on identifying professional needs for CPD and evaluating the learning outcomes.⁹⁶

Also CPD will be more successful if all parties (the practitioner, the professional body, the employers and those providing the CPD training) are working together to support each other in the process. As Christopher Higgins stated: 'Successful continuing education in management will only come about if the attitudes of employers are favourable and if organizations, individual managers and schools create realistic and fruitful partnerships.'⁹⁷

Conversely Cyril Houle stated that CPD is not productive if it is perceived as inappropriate, monotonous, irrelevant and only devised as a public relations exercise.⁹⁸ Other obstacles to CPD includes lack of awareness of what CPD is, lack of time, arrogance, timidity, laziness, competitiveness and the fact that some practitioners work in isolation.⁹⁹ Some CPD projects encourage professionals to comply by offering points or reward systems. But Nigel Hughes asked, 'does this sort of a points and quota regime really achieve the object of the exercise, which is the maintenance of standards of professional competence?'¹⁰⁰

Frankie Todd also believed that CPD will not be successful if it is not formally implemented. For example, if participation is arbitrary, no records are kept and/or if there are no formal mechanisms for supporting and working on the skills and knowledge learnt CPD will be

⁹⁶Ibid.

⁹⁷Higgins, Christopher, 'Continuing Education in Management,' in *Education for the Professions. Quis Custodiet...?* ed. Sinclair Goodlad (Guildford: The Society for Research into Higher Education and NFER-Nelson, 1984), p.229

⁹⁸See Houle, Cyril, 'Overview of Continuing Professional Education,' in *Education for the Professions. Quis custodiet...?* ed. Sinclair Goodlad (Guildford: The Society for Research into Higher Education and NFER-Nelson, 1984), pp.191-196

⁹⁹See Crockett, Heather, and Geale, John, 'The Lone Professional,' in *Continuing Professional Development. Perspectives on CPD in Practice*, ed. Sandra Clyne (London: Kogan Page, 1995), pp.125-132

¹⁰⁰Hughes, Nigel, 'The Rabbits and the Lettuces - The Dual Role of Professional Bodies,' in *Continuing Professional Development: Perspectives on CPD in Practice*, ed. by Sandra Clyne (London: Kogan Page, 1995), p.66

ineffective.¹⁰¹ Eraut agrees that CPD projects can be more successful if they are carefully advertised and promoted.¹⁰²

The APMT was careful to implement a CPD scheme prior to it becoming a requirement from the HPC. As such, those music therapists who logged their CPD activities were doing so on a voluntary basis. In fact 85% of the APMT members believed that CPD was a worthwhile activity¹⁰³ and so it is hoped that once compulsory CPD is imposed by the HPC on the music therapist in the UK in 2005 there will be few complaints or criticisms of this form of accountability. This approach to CPD links with the 'benefits model' described by Rapkins where new, developing professions such as music therapy will implement CPD projects which rely on self-monitoring and the self-motivation to learn new skills.

Wendy Magee led the CPD Committee for the APMT and explained that the 'DoH invited the AHPs [Allied Health Professions] to seek funding for a multi-professional project on demonstrating competence through CPD on the basis of a draft outcomes model developed by the Chartered Society of Physiotherapy.'¹⁰⁴ The Chartered Society of Physiotherapy (CSP) is the largest professional body under the Health Professions Council and the music therapy profession in the UK translated the Chartered Society of Physiotherapy's CPD project into a project that suited the practice of music therapy. Magee noted that the CPD model created by the CSP fitted well with music therapy practice but it is this kind of inter-professional collaboration demanded by the HPC that has caused concern, particularly amongst the smaller professional bodies working under the auspices of the HPC. The music

¹⁰¹See Todd, Frankie, ed. *Planning Continuing Professional Development* (London: Croom Helm, 1987)

¹⁰²Eraut, *Developing Professional Knowledge and Competence* (1994), pp.41-42

¹⁰³See Hughes, Philip, *Report on a Survey of the APMT* (Unpublished: 2000)

¹⁰⁴APMT AGM minutes (16.3.2002), p.15. This report noted that the project would be funded by the DoH, would cover the whole of the UK and run for 18 months, would involve all the AHPs and would be managed by the CSP on behalf of all the professions involved. The project involved the following professions: Association of Professional Music Therapists, British Association of Arts Therapists, British Association of Prosthetists and Orthotists, British Dietetic Association, British Dramatherapy Association, British Orthoptic Association, British Paramedic Association, Chartered Society of Physiotherapy, College of Occupational Therapists, Institute of Biomedical Therapists, Royal College of Speech and Language Therapists, Society of Chiropodists and Podiatrists and Society of Radiographers.

therapy profession would have been disadvantaged if the CPD model used for the Chartered Society of Physiotherapy was not compatible with ethos of the music therapy profession.

I now turn to a third aspect which is included within this section on accountability. I am suggesting that, to a greater or lesser extent, music therapy research projects have recognised and engaged with the demands of accountability.

Research - a Response to Accountability

In terms of the profession, research helps music therapists to document their clinical effectiveness and to establish their credibility within the educational and health communities. Such documentation improves our accountability and clinical status, while greater credibility increases our job opportunities, salaries, and career possibilities.¹⁰⁵

Wigram argued that the music therapy profession in the UK needs to embrace the growing requests for evidence on the effectiveness of the treatment. He stated that '... the lack of formal assessment procedures still constitutes a weakness in our discipline'¹⁰⁶ and Helen Odell-Miller suggested that the publication in 2000 of two government papers, *Meeting the Challenge* and *Promoting Research in Nursing and the Allied Health Professions*, has made this a high priority for the profession. The government is making demands of the music therapy profession to produce evidence on the effectiveness of the work. These demands have had a direct impact on the profession as Odell-Miller noted:

The inclusion of music therapy in central government is a milestone for music therapy, and in the UK we need to challenge the notion that Evidence Based Research is more prevalent in the USA for example, as stated in *Promoting Research in Nursing and the Allied Health Professions* (p.41). This Government Research Report also calls for more funding for Allied Health Professions Research. This points to the importance of developing specific music therapy research departments based in universities, but strongly linked to clinical services ... In the UK this has never been so important, but also never so possible, because since State Registration, and recent modernisation initiatives in the NHS particularly, music

¹⁰⁵Bruscia, 'Professional Identity Issues in Music Therapy Education,' p.25

¹⁰⁶Wigram, 'Indications in Music Therapy: evidence from a treatment for Autistic Spectrum Disorder (ASD); meeting the challenge of Evidence Based Practice' (2002), p.13

therapists as part of the larger Allied Health Professions group, should have more access to funding.¹⁰⁷

The government established the National Institute for Clinical Excellence (NICE) in 1999 in order to gather information regarding the variety and effectiveness of treatments on a number of health issues. Professions are invited to provide evidence on any of the health issues being investigated by NICE and thus becomes 'stakeholders' in the process. However, the current lack of resources held within the APMT (primarily human and financial resources) means that the music therapy profession in the UK has not felt able to be work within this scheme.

However, Wigram offered a clear view of how the music therapy profession might be able to engage with evidence-based research.¹⁰⁸ He explains that the lack of standardisation, evaluation tools and research techniques have weakened the field of music therapy which has been particularly difficult when purchasers are demanding more evidence of cost and clinical effectiveness. He believes that the profession is naive to think that it does not need to engage with these demands:

At this time, an increasing number of challenges are being presented to music therapists to demonstrate that they are providing treatment and interventions that are supported by studies, articles and expert opinion within the hierarchy of Evidence Based Practice.¹⁰⁹

Music therapy cannot escape scrutiny, so we might as well be prepared, or funding to pay for music therapy services will be eroded and ultimately withdrawn for lack of evidence. That is a depressing thought - the more so because of an overriding conviction by not only music therapists, but related disciplines as well, of the significant value and effect of music therapy. The preparation and presentation of arguments and evidence assume increasing importance - not only for therapists established in clinical work, but for newly-qualified therapists coming into the

¹⁰⁷Odell-Miller, Helen, Peer Review Response to Tony Wigram's article, "Indications in Music Therapy: evidence from a treatment for Autistic Spectrum Disorder (ASD); meeting the challenge of Evidence Based Practice," in *British Journal of Music Therapy* (Vol. 16 (1): 2002), pp.26-27

¹⁰⁸Wigram, 'Indications in Music Therapy: evidence from a treatment for Autistic Spectrum Disorder (ASD); meeting the challenge of Evidence Based Practice' (2002)

¹⁰⁹Ibid., p.18

market and needing the 'ammunition' to argue for the development of music therapy services.¹¹⁰

Wigram suggests that music therapists need to learn to use the language of evidence-based research and practice in order to argue for the continuation of music therapy services. Steinhaus and Wright-Bower, cited earlier, also stated that the music therapy profession would benefit from employing language used by administrators to secure jobs. I suggest that describing music therapy in language other than technical or specialist music therapy language does not de-value the care given to the clients. Wigram highlights that the core values of music therapy would not be undermined because there is 'an overriding conviction by ... music therapists ... of the significant value and effect of music therapy.' I argue that, by ensuring more secure job opportunities, attention to the needs of the clients is maintained.

Angela Fenwick's suggested that the APMT, in collaboration with the other arts therapies, ought to consider the relevance of research for the development of the profession as well as the discipline. She noted the following four points:

1. Marketing of, and funding for, arts therapies sessions must be related to 'Evidence-based Practice,' which is dependent on published research.
2. A unified national image of the Arts Therapies encourages confidence both in purchasers/providers and in service-users.
3. The CPSM has confirmed that co-operation between the Associations is essential for State Registration - the Research Group is evidence of such co-operation.
4. Guidance for those doing research at varying levels and the benefits which we can all gain from sharing information with each other within a co-ordinated structure ... is enhanced by such co-operation.¹¹¹

Fenwick highlighted the need for support between the other professions, particularly the other arts therapies. The significant changes to the NHS policies and the growing demands for evidence-based practice has been stretching the music therapy profession considerably. Mary Simmons began her Chairperson's report for the APMT AGM on 4th March 2000 as follows:

¹¹⁰Ibid., pp.23-24

¹¹¹APMT AGM minutes (8.2.1997), p.31

The past two years have been characterised by change. We have seen the introduction of state registration. We are setting up a Continuing Professional Development scheme and working on our web-site ... Key factors that have emerged have been the need for more accountability, transparency of services and better communications between various groups within the organisation [APMT]. Externally, we are looking for closer relationships with our fellow arts therapists and are working to improve our communications with potential employers.¹¹²

Inter-professional collaboration is, according to Larson, an important aspect of the process of professionalisation. This is something that can be undertaken by individual practitioners within multi-professional teams and between professional bodies. Both corporate and individual collaboration have advantages and disadvantages.

The Standing Committee of Arts Therapies Professions was established at the end of the 1980s to offer support and an opportunity to share information and understanding between the arts therapies (which included dance-movement therapy as well as music, art and drama therapies). It wrote a joint document entitled *Artists and Arts Therapists: a Brief Discussion of their Roles within Hospitals, Clinics, Special Schools and in the Community*.¹¹³ There was a growing sense that working together might help to develop a stronger voice and thus a growing awareness from the public. However, it was the founding of the Allied Health Professions Forum that heralded a larger, more vocal organisation that could help to support the professional needs of the arts therapies at this time.

The Allied Health Professions Forum

The Allied Health Professions Forum (AHPF) was established in the 1990s to represent the Professions Allied to Medicine (PAMs). Whilst the body understood that the protection of the public was paramount it was concerned that the professions themselves would need to be given enough opportunities to raise their own concerns (especially within the fast changing world of the NHS) and to ensure that pertinent issues were kept in rather than out of the negotiations. The music therapist Emma Bishton wrote about the benefits for the

¹¹²APMT AGM minutes (4.3.2000), p.2

¹¹³APMT AGM minutes (20.1.1990), p.16

music therapy profession of joining the Allied Health Professions Forum (AHPF) which brought together twelve professional bodies covered by the CPSM/HPC:

It acts both as a formal conduit for consultations with the DoH and as body for representing the interests of the professions. The Arts Therapies ... are, of course, viewed by other professions and indeed by the DoH very much as one profession rather than as separate ones share two seats on the AHPF ... All of the other professions represented have paid officers who take on much of the work involved. Our membership of AHPF enables us not only to benefit from the expertise of these officers when responding jointly to consultations, but also to raise the profile and awareness of the arts therapies within the multi-professional arena.¹¹⁴

One of the most important documents written by the AHPF was a response to the Government Consultation paper entitled *Modernising Regulation - The New Health Professions Council*.¹¹⁵ Much emphasis was placed on creating better protection for the public and the HPC was seen as the new enterprise to ensure that this occurred. The AHPF sensed that this Government Consultation perceived the professions to be defensive, uncooperative and 'opposed to better regulation, in the interest of "protecting" their memberships.'¹¹⁶ However, the AHPF was concerned that some proposed policy changes would eventually lead to less professional power. For example, the government suggested that the Secretary of State could replace the Privy Council for overseeing the HPC. However, the Privy Council is, or at least is perceived to be, slightly removed from the government and therefore possibly more impartial than the Secretary of State. As the AHPF stated, 'this is an important matter of public and professional trust in an essentially independent regulatory process.'¹¹⁷

These comments suggest that the AHPF and the APMT were becoming more interested in protecting the profession rather than the public. The primary task for the HPC is to protect the public. However, I argue that, if the HPC disregards the expert opinion of the music therapists themselves and makes demands which are inappropriate or contrary to the service

¹¹⁴APMT AGM minutes (6.3.2001), p.2

¹¹⁵Allied Health Professions Forum, *Allied Health Professions Response to the Government Consultation on 'Modernising Regulation - The New Health Professions Council'* (1.11.2000)

¹¹⁶Ibid., p.13

¹¹⁷Ibid., p.21

offered by the music therapy profession, the needs of the clients may not be met. I suggest that, by protecting the music therapists themselves and protecting the appropriate standard of professional service, the APMT is also protecting the interests of the clients. Whilst the HPC seemed concerned that self-regulation by professions was potentially unsafe, the professions themselves felt that this was the most secure way of offering public protection. The AHPF stated:

2.2 the *raison d'être* of professions is to guarantee, as far as possible, the safety and well being of the public through the guarding of the standards of practice of the profession ... 3.3.1 True professional self-regulation would mean that each discipline should really require a separate regulatory structure, although the AHPF is not arguing for this ... it is based on a careful analysis of what the concept 'profession' means.¹¹⁸

Another aspect of collaboration which touches on the professional practice of music therapy in the UK is multi-professional team work. In 2001 Emma Bishton stated that State Registration had encouraged more opportunities for multi-professional liaison within the health service.¹¹⁹ It was noted that the 'delivery of health-care has changed radically since 1960 and continues to evolve ... it is clear that there is a move away from independent professionals and towards multi-professional team working.'¹²⁰ As such 'music therapy should be regarded as part of a multi-disciplinary practice, not as an alternative to medical practice.'¹²¹

David Aldridge stated that closer collaboration with colleagues could be attained through shared education programmes¹²² and suggested that teams might be more productive if there is a more fluid exchange of knowledge. However, other music therapists have been less enthusiastic about such close collaboration seeing it as inappropriate and potentially damaging to the field of music therapy. For example, both Isenberg-Grzeda and Parker-

¹¹⁸Ibid., p.13 and p.14

¹¹⁹See APMT AGM minutes (6.3.2001)

¹²⁰J. M. Consulting Ltd, *The Regulation of Health Professions: Report of a review of the Professions Supplementary to Medicine Act (1960) with recommendations for new legislation* (1996), p.49

¹²¹APMT AGM minutes (8.2.1992), p.13

¹²²David Aldridge, 'of Ethics and Education: Strategies for Curriculum Development' (2002)

Eames¹²³ stated that collaborative work could blur the boundaries between different disciplines and thus threaten the unique skills of each profession. Isenberg-Grzeda felt that it was important to reinforce 'the concept of a unique contribution to the interdisciplinary team'¹²⁴ rather than share professional knowledge and run the risk of de-professionalisation.

Although the issue of confidentiality is important for the music therapy profession it can cause issues within multi-professional team meetings. Helen Odell-Miller noted that this is a significant problem for therapists working within large mental health institutes because there is a need to balance carefully the clients needs with the requirements of the institution. She suggested that some team members consciously or unconsciously are envious of the confidential, private relationship therapists have with their clients:

Several issues arise ... one ... is the model of music therapy and how much the ward understood this as a form of psychotherapy or simply as a music-making session. Also, could the ward team be unconsciously sabotaging the therapy as a result of taking on the anxieties of the patient? In addition, there could have been mistrust arising from envy of the individual private relationship with the therapist ... it seems that defining *exactly* what the therapy is for, writing this down including clear referral criteria, and stating what type of model is to be used, goes at least some way to solving the problem.¹²⁵ (*italics in the original*)

Fiona Ritchie also recognised the frustration and annoyance encountered within teams but she wonders whether music therapists are doing all that they can to encourage good working relationships. She suggested that if music therapists are to work within multi-professional teams it is important to attempt to demystify the work. She suggests that 'what we [music therapists] need to do is agree with our clients what is confidential, and what can be discussed at meetings.'¹²⁶

¹²³See Parker-Eames, *Professionalisation of Music Therapy* (1993)

¹²⁴Isenberg-Grzeda, 'Music Therapy Assessment: A Reflection of Professional Identity' (1988), p.166

¹²⁵Odell-Miller, Helen, 'Working with a multidisciplinary team,' in *British Journal of Music Therapy*, (Vol. 7 (1): 1993), p.25

¹²⁶Ritchie, Fiona, 'Teaming Up,' in *British Journal of Music Therapy* (Vol. 7 (1): 1993), p.25

The demystification of the work has been an issue for the field of music therapy in the UK for many years. It has become more significant for the music therapy profession in the UK to learn how to collaborate effectively with other professions particularly because of the growing trend towards multi-disciplinary team work. In this chapter I have described the strong links made by the APMT and the Allied Health Professions Forum and the Health Professions Council. I have argued that effective communication between professions is a priority for the APMT.

I have covered many aspects of the music therapy profession in the UK. Primarily I have explored how the music therapy profession has worked under the umbrella of the Council for Professions Supplementary to Medicine/Health Professions Council. Both this chapter and the previous chapter have identified a number of benefits that the music therapy has perceived it has gained from becoming a member of the CPSM/HPC. However, I have also described the growing amount of demands being put on the music therapy profession in the UK. The small size of the profession has meant that it has struggled to remain a visible presence within the HPC especially as the HPC has grouped the three arts therapies together and this has meant that the music therapy profession in the UK has sometimes been represented by drama and art therapies.

Growth and Apathy within the Music Therapy Profession in the UK

There are numerous comments peppered throughout the minutes of the APMT meetings that express concern about the apathy of members.¹²⁷ However, because the only source of this information comes from the APMT archives themselves it might be that the members were apathetic only towards the Association and not within aspects of their own clinical work. Responses to the survey on job satisfaction undertaken by David Stewart were most prolific amongst newly qualified and those who had been working as music therapists for 10 years or longer. Although he does not offer a clear reason for this trend it does seem to link with the general lack of responsiveness that the APMT office has found for many years.

¹²⁷See for example, APMT AGM minutes (17.1.1987)

The relatively small number of music therapists in the UK is a major problem for the profession as it attempts to develop and promote itself. In 1981 Wigram believed that a more unified and supportive attitude within the music therapy profession in the UK would offer a more impressive image to the outside world and he predicted that, if the growing numbers of qualified music therapists were aided by a supportive and collaborative attitude, the music therapy profession could move from strength to strength:

It is perhaps interesting to note that since the Music Therapy courses began in 1969 we have accumulated in the Association eighty five members. Many more have been trained than that and it is sad that we have only that number of practising Music Therapists in the country. However looking to the future at a rate of thirty students a year, we should have 250 qualified and practising Music Therapists within five years, and looking optimistically at the long term prospect, after thirty years there could be over one thousand Music Therapists in Great Britain if the profession continues to expand the way it has done over the last ten years.¹²⁸

In fact, since 1992 four more fully validated training courses have been founded in the UK. A new music therapy course in Bristol was founded at the beginning of 1992. This part-time, two year course offered a new approach to training intended to appeal to a people who could not fit into a one year full-time course. It also aimed at attracting musicians from non-classical backgrounds. This course was also the first to exist outside the Greater London district offered more opportunities for music therapy throughout the UK.

Two years later a course at Anglia Polytechnic University, Cambridge was launched which included the addition of an MA in music therapy.¹²⁹ The inclusion of an MA course added more weight to the image of music therapy as a specialist academic subject. The Welsh College of Music and Drama introduced a music therapy course in September 1997 which was approved by the APMT and another post-graduate diploma course began at the University of Edinburgh in October 2002 which was another Nordoff-Robbins training course.¹³⁰ Wigram's prediction of the number of qualified music therapists was based on

¹²⁸APMT AGM minutes (7.11.1981), p.2

¹²⁹Master of Arts degrees need to be validated by Universities, unlike diplomas which could be validated by Institutes of Further Education.

¹³⁰Moray House, School of Education, University of Edinburgh. By 2000 the CPSM had taken over validating courses and maintaining standards within initial music therapy training, supervision and post-qualification training. See APMT AGM minutes (4.3.2000), p.4

only three training courses. Despite the existence of seven validated training courses there are not a thousand practising music therapists in the UK which indicates that many qualified music therapists do not continue to practice.

Another strain that has occurred for the profession has been that the APMT has been asked to produce information about clinical effectiveness for the National Institute of Clinical Excellence (NICE) and to become a stakeholder for specific health issues. The manner in which NICE wants to collect information regarding clinical effectiveness, the time scale in which it is making these demands, and the way in which it expects the information to be presented by each profession can be seen to challenge the resources of the music therapy profession. The APMT recognises that it needs time to consider how it can respond to these demands and the issue of producing more research material is something which needs addressing most effectively through the training courses. These are large issues which need to be explored in more depth. What is plain from the material held within the APMT archives is the apparent enthusiasm for the music therapy profession shown by potential and actual music therapy students which is somehow not followed through once qualification has occurred.

Jobs

By the mid 1990s more students were graduating than there were jobs advertised. Although posts were being created, they did not offer security since most jobs were being created on a sessional basis. The jobs that were available were within voluntary or charitable organisations and many posts were not being continued if a therapist left a position. Diana Asbridge, APMT Administrator stated that 'jobs for music therapists remain thin on the ground, and a note of caution must be sounded if further new courses are to be considered. The role of the APMT in monitoring this situation is vital for the health of the music therapy profession.'¹³¹

¹³¹APMT AGM minutes (11.2.1995), p.4

In 1996 Diana Asbridge again raised concerns that the lack of jobs could lead to 'a growing body of unemployed, newly-qualified music therapists.'¹³² She highlighted that there were approximately 60 students qualifying each year there were a total of 49 advertised jobs during 1995 and it was noted that 'of last year's students "not many" were in work and many were supplementing their music therapy work with other jobs.'¹³³ Yet again in 1997 Asbridge cautioned the music therapy profession thus:

... there was a slight increase in jobs advertised in 1996, but this was still totally inadequate to keep over 300 employable music therapists in jobs. We remain in a situation where new music therapy courses should be considered with great caution, except perhaps in areas well away from London.¹³⁴

The APMT was looking into ways in which it might support the employment needs of music therapists including advice on undertaking private practice, getting and maintaining work, presentation skills and administration and organisational skills. Whilst the APMT can continue to offer in-house support many responsibilities of the APMT have been taken over by the HPC. For example, prior to State Registration the APMT determined who was entitled to practice. The HPC also validates the training courses and, in 2005, requires that professionals undertake formal CPD work. The APMT is aware that music therapists only need to come under the umbrella of the HPC in order to practice and that its financial position is very precarious if music therapists decided not to renew their membership of the professional body. It may be that, in the twenty-first century, the APMT needs to radically change its services to its membership to ensure its survival.

In a working paper for the review of the supervision scheme Mary Simmons put some issues forward including the problems facing the profession at the turn of the century:

1. Lack of jobs creating huge insecurity within most music therapists.
2. Precarious funding for many jobs
3. Many people having to act as a 'pioneer' which requires many extra skills over and above music therapy clinical practice.

¹³²APMT AGM minutes (10.2.1996), p.4

¹³³Ibid., p.16

¹³⁴APMT AGM minutes (8.2.1997), p.8

4. MT seen as a 'nice to have' rather than a necessity and is often seen as a priority in cutting the budget.
5. Sometimes seen as too isolated within a team of workers - often using language that is too technical for other members of a team.
6. The work is hard enough but additionally, many people find difficulty in creating a suitable working framework that enables them to concentrate on clinical work.
7. The advent of state registration is potentially divisive by allowing members to be registered without necessarily being members of the association.¹³⁵

On a similar note the NHS published a document entitled *NHS Career Development Initiative for the Professions Allied to Medicine* and realised that, although CPD was being conducted it was difficult for Professions Allied to Medicine (PAMs) to progress or have a hierarchical career path. It listed seven barriers to professional development:

1. There is a perceived lack of management support for PAMs' development, which includes lack of knowledge about their roles and expertise, little encouragement for those taking on new initiatives and poor reward systems.
2. Time and work pressures for both managers and staff have contributed considerably to the above. Insufficient trained staff in some professions has led to resources being too thinly stretched to allow adequate supervision of junior staff.
3. PAMs find it increasingly difficult to get away from the workplace to undertake career development and study leave arrangements are variable, and in some cases non-existent.
4. Particular difficulties exist for PAMs who work single handedly in rural localities or across organisations. The shift towards a primary care led NHS has sometimes exacerbated this with some working in isolation in the community.
5. Traditional and sometimes inflexible work patterns have done little to resolve this situation. New ways of working and encouragements of family friendly policies have left these professions largely untouched.
6. Few appraisals and poor quality appraisal mechanisms are a significant barrier and are responsible for much unfocused development.
7. PAMs find funding extremely difficult to access.¹³⁶

This document recognised that short career paths have a direct impact on retention of professionals and it suggested 'the link between training, changes in practice and job satisfaction [should be clarified] ... and there should be greater equity among the Professions

¹³⁵APMT, Working paper for the Review of the Supervision Scheme (February 2000), Document held within APMT archives. File BL:2, p.1

¹³⁶National Health Service, *NHS Career Development Initiative for the Professions Allied to Medicine*, (Undated) Document held within APMT archives. File BL:1, pp.3-4

in terms of shadowing, job swaps, mentoring, coaching and secondment within and outside their organisations.’¹³⁷

One move to enable Professions Allied to Medicine to gain professional recognition and to reach higher levels of office has been the creation of consultant allied health professionals. The NHS paper, *Agenda for Change*, demonstrates a commitment to extending career structures for Allied Health Professions by creating clinical consultants. Expert clinical practice would be the core function of consultants with other skills including professional leadership, practice and service development, research and evaluation and education and professional development. *Agenda for Change* states that the NHS ‘will work with the professional organisations to ensure thresholds for expert and leadership roles give fulfilling careers which are fairly rewarded.’¹³⁸ *Agenda for Change* is a document which may have significant implications for the music therapy profession in the UK but these have not been discussed in this dissertation because the APMT is, at the time of writing, in the process of conducting negotiations with the NHS on behalf of its members. However, an anonymous document written by an occupational therapist and held within the APMT archives offers a stark vision for the future of the Professions Allied to Medicine:

...to miss the boat at this time ... would be professional suicide for us as a profession [Occupational Therapy]. Colleagues in Physiotherapy and in particular nursing have

¹³⁷Ibid., p.23. The Department of Health published a number of documents to help support the pay and conditions of the arts therapies. Emma Bishton wrote about two documents from the Department of Health:

1. PAM Career Development Initiative, to examine by region PAM access to continuing professional development, patterns of career development and access to management training. Part of the Initiative is a recognition of the need for Career Development for PAMs.
2. National Enabling Agreement on Grading. This allows for some flexibility within the PAM grades; it is designed to address specific problems in the current grading structure, rather than initiate wholesale local regrading. However, it may be of use to music therapists stuck at the top of Senior I and unable to apply for upgrading according to the current definitions of Head III, as the PAM PT ‘A’ Staff Side guidance on the enabling agreement suggests that ‘Head III’ definition *could* be expanded to include a) work in a discrete service or geographical locality team without direct supervision from a member of own profession, b) PAM responsible for delivering specialist treatment or specialist diagnostic procedures, c) specialist clinician who undertakes the initial assessment of a patient and refers direct to consultants or other health care profession prior to medical assessment. APMT AGM minutes (8.2.1997), p.1

¹³⁸National Health Service, *Agenda for Change, Modernising the NHS pay system* (12.1.05), point 18

embraced the potential to extend their scope of practice. However, this has been achieved with an element of political confidence in numbers and in profile.¹³⁹

Despite the complicated policy changes for practising music therapists which may have contributed to the reasonably high drop-out rate of music therapists in the UK, the training courses are inundated with enquiries regarding training, qualification and job prospects. The perceived apathy amongst its members is a concern for the APMT as it may significantly undermine the organisation which is run on a voluntary basis.

Conclusion

I have shown that the authority of the medical profession at the end of the twentieth century and into the twenty-first century has been eroded by increased technology, the recognition of patients' rights and the accountability and scrutiny imposed on it by NHS management.¹⁴⁰ The medical profession might have felt that it could have retained some status and power by becoming more involved with the management side of the NHS. Certainly the government has been hoping to strike 'a new balance between professionalism, bureaucracy, managerialism and accountability.'¹⁴¹ Michael Bury commented on the changing demands and expectations of both the public and the professions:

Today, lay people are obliged to have views about a whole range of products and lifestyles, including those pertaining to health. These views are then expected to be translated into informed choices ... Indeed, the systems that earlier catered for *needs* in such areas as health and welfare now emphasise *preference* and consumer satisfaction.¹⁴² (italics in the original)

It can be seen that the speed with which the government has introduced new policies for the NHS has played a large part in stretching the resources of music therapy profession in

¹³⁹APMT, *Extended Scope Practitioner. Professional Maturity or the beginning of the end.* (Source unknown: undated). Document held within APMT archives. File BL:1, p.12

¹⁴⁰See Walby, and Greenwell, *Medicine and Nursing - Professions in a Changing Health Service* (1994), pp.74-75

¹⁴¹Carrier, and Kendall, *Health and The National Health Service* (1998), p.357

¹⁴²Bury, Michael, 'Postmodernity and Health,' in *Modernity, Medicine and Health: Medical Sociology Towards 2000*, eds. Graham Scambler and Paul Higgs (London: Routledge, 1998), p.4

general and the APMT in particular. In the previous chapter I explained that the APMT had been excited to come under the umbrella of CPSM because it was seen that this would offer official recognition, firm support and positive inter-professional collaboration. However, I suggest that what the APMT did not foresee was the imposition of fast-changing government policies and this chapter has emphasised that the music therapy profession has found these new demands difficult. As such, the APMT has had to work hard to cope with these demands and its focus has been on the needs of the profession rather than the needs of the field of music therapy as a whole. This perceived imbalance may have helped to instigate the criticisms of the professionalisation of music therapy amongst the proponents of Community Music Therapy.

In the conclusion I explore the criticisms of the professionalisation of music therapy from some of the proponents of Community Music Therapy and offer my own arguments within this debate. I draw together the findings from each chapter which investigates the manner in which the music therapy profession has engaged with the process of professionalisation.

Conclusion

'Perhaps, as a profession, music therapy desires to bask in the respectability of medicalism, hence choosing to concentrate on issues such as state registration at the expense of the breadth of services available to users. Or perhaps individual music therapists are simply reluctant to abandon the status and authority that medicalism confers upon them ... We must not merge entirely into a medicalised professional hierarchy: to empower and enable, wherever we work, we need hearing minds and radical hearts. And if that means being regarded as mavericks and naïve, then so be it.'

Proctor, 'Empowering and Enabling - Music Therapy in Non-medical Mental Health Provision' (2003)¹

I recognise that there are concerns that the process of professionalisation is a political act which focuses on the needs of the profession rather than the needs of the clients. In this conclusion I take further my argument that the music therapy profession has engaged with the process not only to support the organisation and the individual music therapists throughout the country but also to support the needs of the clients. Therefore, I argue that this has not contradicted the value of caring for clients. I suggest that the health and integrity of the whole field of music therapy is essential in order to offer a strong foundation of support for the therapist-client relationship.

To date there has been no in-depth research conducted on the professionalisation of music therapy in the UK and I have integrated concepts from sociological theories on professionalisation with research into the development of the music therapy profession in order to understand the situation more fully. Magali Larson considered that professionalisation is a complex process involving careful negotiations between the profession itself, clients, society and the state. In this conclusion I review Larson's theory in conjunction with the historical development of the music therapy profession in the UK before exploring the comments and criticisms made by some music therapists about the process of professionalisation and drawing some final conclusions.

¹Proctor, 'Empowering and Enabling - Music Therapy in Non-medical Mental Health Provision' (2003), p.100 and p.106

The Process of Professionalisation - an Overview of the Development of the Field of Music Therapy

1. Starting point - ie. creation of a 'formal organisational group.'
2. Overall objective of the 'organisation' - the desire to pursue a project.
3. Sub-goals - Establishment and maintenance of a market.
Accredited training courses.
Monopolisation of professional knowledge.
Respectability.
4. An 'organisation' will want to work with allied professionals.
5. An 'organisation' will begin to recognise the wider context - social, political, cultural - in which it is working.²

Magali Larson offered a structure for the process of professionalisation which an occupation needs to work through in order to move towards professional status. Larson stated that the first step of the process is the creation of a formal organisation. The founding of the Society of Music Therapy and Remedial Music (which became the British Society of Music Therapy) clearly fulfils this starting point. The individuals who worked within the field of music therapy were galvanised by a desire for support and a chance to learn from each other. The early bulletins of the Society demonstrate how the styles of work were wide ranging and it is possible to see that the publications and the meetings within which the practitioners shared their knowledge offered vital fora through which the isolated practitioners could learn.

Although the Society did not have any intention of working towards the professionalisation of music therapy it could be said that its very existence started the process which galvanised collaboration between practitioners. This collaboration may have instigated common trends and similar approaches among the members which could be seen as the beginning of the setting of standards in an informal manner throughout the field.

Larson stated that the overall objective of an organisation is the desire to pursue a project. For the Society its aims and objectives were to promote the study of music therapy and to disseminate information to interested parties. This focusses more on the discipline and the professional practice of music therapy than on the profession itself.

²See MacDonald, *The Sociology of the Professions* (1995), chapter 7

In the 1960s and early 1970s the field of music therapy in the UK was in its infancy, at a stage when it was not ready to consider work issues such as the monopolisation of a market or the formal recognition of the field through set pay and conditions. It was due to the founding of the first training course and the subsequent recognition of qualified music therapists that the Association of Professional Music Therapists was formed in 1976. This was an independent organisation, separate from the British Society of Music Therapy, with the specific role of supporting qualified music therapists. I demonstrate that the division created between qualified and unqualified practitioners by the introduction of formal qualifications was a pivotal moment in the development of the music therapy profession. There was a recognition that the needs of the qualified music therapists were different from those who had not qualified and I argue that this development can be seen as the formal beginning of the professionalisation of music therapy in the UK. Without the support of the APMT, these qualified music therapists would have struggled to gain formal recognition. The music therapists themselves recognised the value of music therapy for their clients and the APMT helped these practitioners to sustain their work. As such it can be seen that the APMT's first obligation was to the therapists themselves and yet, without this security and support for the therapists, the work itself may have suffered.

It was the work of the APMT that propelled music therapy into the process of professionalisation. The work of the Society was vital in creating an arena from which this process could begin because it brought music therapists together and offered a forum for publications and encouraged discourse. However, it was the APMT that engaged more directly with the process. The validation of training courses and the negotiations to secure pay and conditions were two significant developments which helped the music therapy profession achieve other goals identified by Larson, namely the establishment and maintenance of a market and the monopolisation of professional knowledge.

Another goal that Larson identified as being part of the process was to achieve respectability. This is a more abstract issue and is reminiscent of the concept of altruism included within Millerson's list of the six traits that can be seen to define professions.³ Professional respectability and altruism are less tangible than the other goals and are jointly

³See Millerson, *The Qualifying Associations. A Study in Professionalization* (1964)

created by the profession and the laity. The music therapy profession may be able demonstrate its respectability by securing positive support from seemingly trustworthy external agencies (for example, from the government, the medical profession and the CPSM/HPC). However, Larson has suggested that if a professional 'service is desirable to the public the professions may well be more successful.' She went on to state that if 'a profession's ideology fits well with the public's/society's ideology this will serve all concerned well.'⁴

In order to secure the public's perception of respectability professions will find it useful to acknowledge contemporary attitudes and social preferences. A profession has a choice as to whether it recognises and adapts to the preferences of the public or whether it chooses to regard public opinion as being irrelevant to its development.

Throughout its development the music therapy profession in the UK has recognised the value of responding to the explicit and implicit demands of the public as an effective method of survival. For example, the APMT recognised the value of attaining external forms of validation for the training courses. This provides the public with a sense that music therapy is a trustworthy authority which, in turn, results in more employment opportunities for music therapists. Although the validation of a training course offers the perception of good practice Ansdell argues that this does not offer an absolute guarantee.⁵

The APMT has joined forces with other allied professionals and become part of a stronger, larger, more vocal and more visible group of professionals. Liaising with other professions is the fourth point within Larson's theory on the process of professionalisation. This development goes beyond the need for supportive comrades. The music therapy profession recognised that it could gain greater levels of respectability if it linked with larger professions allied to medicine and it has come under the umbrella of CPSM/HPC. The prime focus of CPSM/HPC has been the protection of the clients rather than the protection of the professions. One reason the music therapy profession joined was to be *seen* to be responsible and to acknowledge the need to protect the clients. I argue that, although the

⁴Larson, *The Rise of Professionalism: A Sociological Analysis* (1977), pp.47-48

⁵See Ansdell, *Community Music Therapy 'Big British Balloon' or Future International Trend?* (2003)

core values of the field of music therapy are to enable and support clients, it is also necessary to be *seen* to be working for the good of the clients. Although this calculated action supports and promotes the music therapy profession itself it does also benefit the clients. Music therapy will blossom if the public are made aware of the responsible attitude of the profession, and I suggest that the growth of music therapy will benefit all parties.

The original reason for coming under the auspices of the CPSM/HPC was to enhance the respectability of the music therapy profession through State Registration. In many ways this move has been detrimental to the profession itself. Other professions within the CPSM/HPC are much larger and thus hold more influence within this Council, thus making it difficult for the needs of the music therapy profession to be noticed or recognised. The Council has the authority to make decisions regarding pay and conditions without reference to the music therapy profession itself. As such, the APMT (which is run *by* music therapists *for* music therapists) has lost much of its influence over the legislative developments for the music therapy profession in the UK and there are growing concerns for its future.

The Right Time to Develop

I agree with Larson's view that '[o]rganisations ... tend to appear ... at the time when it is precisely possible to found them and when they can function effectively with their new structure.'⁶ The music therapy profession has been able to use the changing public attitude to its advantage. The changing attitude to the authority of the orthodox medical profession has shifted the balance of power away from the medical profession and opened up opportunities for the complementary medicines to move more directly into the public eye. Also the introduction of the internal market, which created purchasers and providers within the NHS, has offered the music therapy profession a chance to promote itself as a viable service.

According to Stige the consensus model of music therapy has embraced a post-modern attitude which he describes as including 'differentiation, commodification, rationalization

⁶Larson, *The Rise of Professionalism. A Sociological Analysis* (1977), p.6

and individualization.⁷ The consensus model has concentrated on work with individuals by offering a service in which space and attention is given to the needs of the individual rather than the needs of the community. In Stige's view this mirrors the post-modern trend towards independent living, separated from community life, in which each person takes responsibility for his or her own needs.

Having created a market and ensured the monopolisation of this market, music therapy has become a commodity. Stige questions to what extent the field of music therapy can engage with the process of commodification with integrity. He considers whether it is appropriate for the healing process of music therapy to be exploited within the marketplace. I have described the way in which the music therapy profession in the UK has promoted itself as a *rational* alternative to orthodox or biomedical treatments which can appeal to the public, but the proponents of CoMT wonder to what extent the field of music therapy can or ought to be rationalised.

Advocates of CoMT argue that the process of professionalisation, including the perceived stages of standardisation, commodification and rationalisation are incompatible with the broader field of music therapy. According to Stige, '[i]f the discipline of music therapy is linked too closely to the profession of music therapy and defined by the needs as they are seen from, say, the professional associations, a critical and constructive potential is lost.'⁸

From this point of view it would seem that the APMT has stifled the flexible creativity that the field of music therapy would like to retain. According to this point of view the APMT's engagement with the process of professionalisation has forced the field to become a narrow specialisation which is interested in defining standards and seeking public approval, not for the good of the client, but for the preservation of the profession. I suggest that Bruscia has identified a significant issue within this argument. Like Stige he explored the concept of the discipline and the profession separately and considered that the discipline is able to be more field-independent than the profession (although neither are fully dependent on, or independent from, the field). The profession is more pressurised by external demands.

⁷Stige, *Elaborations toward a Notion of Community Music Therapy* (2003), p.183

⁸*Ibid.*, p.221

Bruscia suggested that music therapists need to be 'fully knowledgeable of and highly skilled in their discipline'⁹ so that they (and the profession as a whole) can cope with the demands placed on the profession. Therefore, the clarity of the identity of the discipline will be able to support the more precarious nature of the identity of the profession.

Critics of the process of professionalisation have been concerned that the focus is on the self-preservation of the profession rather than on the development of the discipline. I would argue that it is important to nurture both elements but that the needs of the profession are different from the needs of the discipline and that the APMT has been focussing its attention on sustaining the needs of the profession. Therefore, it is understandable that any criticisms of the professionalisation of music therapy have been directed towards the APMT. Despite my argument that these criticisms are misleading I do suggest that these comments can help remind the profession in general (and the APMT in particular) that the discipline and profession (and professional practice) need to be developed and nurtured together.

Despite the fact that proponents of CoMT criticise any engagement with the process of professionalisation I suggest that there are three elements of the process of professionalisation within Larson's theory which have also impacted on CoMT. The first is the establishment and maintenance of a market. Proponents of Community Music Therapy suggest that it has emerged to offer a unique service within health care. Although it may be too early to predict, CoMT may have found a market within the caring professions because these projects offer support for communities as complete entities. Stige explains that other forms of professional help focus on supporting the individuals living within these communities rather than the communities themselves, hence his suggestion that CoMT is offering a unique type of support.

The development of CoMT in the UK has coincided with the introduction of the government scheme, Care in the Community. This coincidence may fulfil Larson's view that organisations emerge at opportune times. CoMT may have found a niche in the market to support these new communities. Ansdell stated that these projects offers something different from both consensus models of music therapy and the services of community musicians. If

⁹Bruscia, 'Professional Identity Issues in Music Therapy Education' (1987), p.27

these projects are offering something valued and unique, then it may be that CoMT will thrive due to the fact that it has monopolised a market.

The issue of respectability, which is another element within Larson's process of professionalisation, also needs to be considered. Advocates of CoMT reject the need to pander to a perception of professional respectability for the purposes of self-promotion. They would like to base the 'success' of each CoMT project on the fulfilment of the clients needs. I suggest that respectability may occur through the positive responses to each CoMT project. Although this may be a by-product of the main work of music therapy and not a main goal of the work, it may nonetheless occur. To what extent a music therapy project has sought respectability for self-promotion and to what extent it has been gained due to the 'success' of its work seems difficult to assess.

The final stage that completes Larson's theory of the process of professionalisation is that the organisation will begin to consider itself within the wider context in which it is working and this includes the social, political and cultural aspects of the environment. Music therapy has engaged with the process of professionalisation fully and, at the beginning of the twenty-first century, I suggest that it has reached the final stage of Larson's theory. It is at this point that publications on CoMT emerged and I argue that these have coincided with the final maturation stage of the process. Stige stated that all CoMT projects need to consider the social, political and cultural contexts within which they exist, a sentiment which mirrors the final stage of professionalisation. Despite the criticisms levelled at professionalisation by the advocates of CoMT, I suggest that it has also engaged with these process.

Stige stated that the reason an occupation engages in the process of professionalisation is to gain privileges such as the monopolisation of a market and perceived respectability. He suggested that a desire to attain these privileges is simply an indication of an insecure and immature organisation. According to Proctor there has been too much emphasis in recent years on professionalisation and on the need to declare the 'success' of the consensus model which panders to the success culture of the western world.¹⁰ His concerns are particularly

¹⁰See Proctor, 'Empowering and Enabling - Music Therapy in Non-medical Mental Health Provision' (2003)

pertinent to this dissertation and it is worth repeating his comments quoted in the Introduction:

As our profession matures and makes the transition from radical, outsider group to accepted, establishment group through processes such as state registration, we must be aware of the dangers of 'professionalisation.' Preoccupation with rising professional status or eagerness to adopt the assumptions of more established disciplines may compromise our ability to offer clients our distinctive skills.¹¹

The Rebellious De-Professionalised Professionals

I have already noted that one definition of CoMT describes it as an 'anti-model that encourages therapists to resist one-size-fits-all-anywhere models (of any kind), and instead to follow where the need of clients, contexts and music leads.'¹² Because there is a rebelliousness against formal definitions or the use of set techniques there is a reluctance to connect the CoMT branch of music therapy to any theory. Penny Rogers emphasised this view when she wrote: 'Uncertainty or not-knowing, so essential in our clinical practice, may conflict with our need to show professional solidarity in our presentation to the outside world.'¹³

Pavlicevic wrote about a specific project within South Africa which, she said, left her feeling de-skilled and her professionalism destabilised.¹⁴ This feeling of vulnerability is something which pervades the descriptions of CoMT case studies. David Stewart explained that, initially, he had been concerned that CoMT might appear 'unprofessional.' However, he began to realise that 'in moving beyond the influence of this idea I am now for the de-professionalisation of some of my knowledge. I am for giving personal knowledge its voice and influence on professional practice.'¹⁵

¹¹Ibid., p.106

¹²Ansdell, *Community Music Therapy 'Big British Balloon' or Future International Trend?* (2003), p.3

¹³Rogers, Penny, 'A Place for Uncertainty,' in *British Journal of Music Therapy* (Vol. 10 (1): 1996), p.3

¹⁴Pavlicevic, 'Learning from *Thembaletu*: Towards Responsive and Responsible Practice in Community Music Therapy' (2004)

¹⁵Stewart, 'Narratives in a New Key: Transformational Contexts in Music Therapy' (2004),

In the UK music therapy has gained formal recognition through the validation of seven training courses, it has been accepted under the umbrella of the CPSM/HPC and other professional organisations, and it has received State Registration as well as secured firm and appropriate pay and conditions. These developments have occurred through APMT's engagement with a process of professionalisation and music therapy in the UK feels confident enough at this stage to recognise that it is stable. This has given the advocates of CoMT the confidence to attempt to rebel. This rebelliousness is based on a foundation of stability brought about *through* the process of professionalisation. I note that all those who are making claims of de-professionalisation are, nonetheless, fully qualified music therapists.

I argue that the development of the music therapy profession in the UK fits neatly within the theory of the professionalisation by Larson. To fit so neatly into one of the main theories would suggest that the development of the music therapy profession in the UK has conformed to expectations. It could be interpreted that it has, knowingly or unknowingly, fulfilled the requirements for successful development. However, Diane Waller has been concerned that the process, which seems to involve intense political wrangling, does not appear compatible with the arts therapies' desire for 'honesty, openness and integrity.'¹⁶ It would seem that the field of music therapy may have a crisis of integrity.

What's Wrong with the Professionalisation of Music Therapy?

There are two significant criticisms raised by the proponents of CoMT. Whilst these are valid concerns and have instigated a critical debate within the music therapy profession, I argue that these criticisms do not consider the full issues involved.

Firstly, it has been argued that the process of professionalisation focuses on the promotion of the profession. This action of self-promotion contradicts the prime responsibility of the music therapy profession in the UK, namely care for the clients. I argue that the music therapy profession *does* take into consideration the needs of the clients. The health of the

p.288

¹⁶Waller, 'Come Back Professor Higgins - Arts Therapists need you! The importance of Clear Communication for Arts Therapists' (2001), p.246

profession as a whole is vital to ensure that individual music therapists are supported in their work. This has a direct impact on the sessions themselves and thus also on the clients needs. To neglect the overall needs of the profession as a whole will impact on the care for the clients, and I suggest that this neglect is dangerous and a false economy.

The second issue concerns the ability or desire to share technical information with those outside the public. Chapter Two investigated the manner in which professions aim to create a balance between sharing concrete knowledge with the public and withholding abstract knowledge. I explained that guarding abstract knowledge helps a profession retain some knowledge and power with which to bargain for higher professional status. Stige argued that the acquisition of abstract knowledge through research should be for the purpose of gaining understanding and should not be used as a bargaining tool within political negotiations. Whilst I agree with this sentiment I recognise that the training courses in the UK are pressurised to educate the students in such a manner as to demonstrate high levels of training, positive pass rates and to promote employable music therapists. There is little financial support for research into the meta-theories on music therapy.

Sharing knowledge, whether internally or externally, requires the establishment of definitions and standards. Proponents of CoMT state that setting standards for the practice of music therapy is a dogmatic action which negates the flexibility and spontaneity necessary to attend to the unique needs of each music therapy session or project. I argue that it is equally dogmatic to refuse to offer any working definitions for CoMT. Establishing standards offers benchmarks from which quality assurance can be measured. This protects all parties and creates an attitude of responsibility and trust. In Chapter Four I explained that this definition of standards differs considerably from the concept of standardisation which describes the imposition of rigid rules. The latter would be inappropriate for the music therapy profession.

I have acknowledged Ansdell's theory of the *Music Therapist's Dilemma*¹⁷ which questions the ability to translate musical processes into verbal language. I have also cited Steinhaus and Wright-Bower's suggestion that the music therapy profession needs to learn to speak

¹⁷Ansdell, *Music Therapy as Discourse and Discipline. A Study of 'Music Therapist's Dilemma'* (1999)

the language of administrators in order to convince them of the relevance of music therapy.¹⁸ Steinhaus and Wright-Bower offer a pragmatic approach to the manner in which music therapy can promote its service. I suggest that, whilst it is important to continue to consider the difficulties in communicating a musical process with words, it is also necessary to engage in a pragmatic form of communication with administrators, employers and the laity.

Inter-Dependence

Bruscia stated that it was not possible for either the music therapy discipline or profession to be completely field-independent or field-dependent. I agree with this statement and also argue that the discipline and the profession cannot be separated from each other. They impact on one another. Bruscia's theory is similar to that put forward by the sociologist Freidson. According to Freidson, autonomy or field-independence is highly desirable and is perceived to be enjoyed by professions. However, it is an unrealistic state because all aspects of a profession are, to differing degrees, subject to external influences and external scrutiny. In order to attain as much autonomy as possible from 'direction from others [and] freedom to perform one's work the way one desires'¹⁹ it is perceived that professions have to struggle against the government's continuous demands for accountability. This theory suggests that the relationship between the professions and the government is characterised by this continuous state of tension.

Aigen also explored the possibilities of an indigenous music therapy discipline which does not rely on techniques and theories from other disciplines. He suggested that a mature discipline might be able to reach this state. However, Streeter argued that borrowing technical knowledge from other sources is not a transitory stage for music therapy but one which needs to be recognised as a valid and potentially permanent arrangement. This debate was discussed in Chapter One and demonstrates that there are tensions regarding the independent nature of the discipline which also has an impact on the independent nature of the profession.

¹⁸See Steinhaus, and Wright-Bower, 'A Conceptual Framework for Marketing Music Therapy to Healthcare Administrators' (1995), pp.82-86

¹⁹Freidson, *Profession of Medicine. A Study of the Sociology of Applied Knowledge* (1970), p.368

I suggest that there is an alternative to this persistently tense *field-independent* and *field-dependent* state. Larson's theory demonstrates that professions move towards contact with other professions, towards *inter-dependence* and reliance on others for growth and support. For the music therapy profession inclusion within multi-disciplinary teams helps to enhance the professional image of music therapy. Chapter Two offered a quotation from Isenberg-Grzeda which stated that 'insistence on the specialized capacities of the music therapist reinforces the concept of a unique contribution to the interdisciplinary team [and] ... establishes a specific technology for music therapists.'²⁰ According to this position it would appear that music therapy can retain its indigenous character and yet work with other professions in an inter-dependent manner.

The theory of inter-dependence can also be seen within a larger context. Chapter Two cited the arguments of Johnson, Larkin and Saks that professions work symbiotically with the government. Both parties need to be seen to be independent from each other in order to demonstrate impartiality. In the case of the music therapy profession, it needs to gain seemingly independent validation from the government to attempt to gain trust from the public. The government needs to be perceived to be insisting on evidence of clinical- and cost-effectiveness to demonstrate that it is acting responsibly.

The concept of inter-dependence offers a pragmatic response to the process of professionalisation. I argue that music therapy has become inter-dependent with other professions in a pragmatic way in order to gain support. This support helps the profession, the therapists and the clients. Erkkilä disagrees with the proponents of CoMT who suggest that it is inappropriate to forge links with bio-medical professions because the values of the latter and music therapy are not compatible:

... we have had to fight for the status and approval of music therapy for years, and we all know that there is no other way to survive than the consensus music therapy. It would be a professional suicide to change the track which links us with the other therapy professions. Psychiatry 'yes,' medical 'yes,' individual 'yes,' we must say

²⁰Isenberg-Grzeda, 'Music Therapy Assessment: A Reflection of Professional Identity' (1988), p.166

but it does not mean that it is impossible to adopt cultural, contextual or community aspects within the consensus model.²¹

Erkkilä stated that the professional identity of the music therapist needs to remain within the medical realm and that it 'is not fully up to us as music therapists to define music therapy - unfortunately. When defining music therapy we must pay attention to the professional context (and culture) next to us. This context consists of psychiatry, psychology, psychotherapy, and medicine.'²²

In Conclusion

More than a profession. Scarcely a living.²³

Where does this leave the music therapy profession in the UK? Is it in a healthy state or is it struggling with its integrity? The music therapy profession supports the health and integrity of its clients. As Ruud stated, music therapy is an effort to 'increase possibilities for action'²⁴ for the clients. The profession also recognises the importance of the therapist's health and integrity and to 'increase the possibilities for action' for the therapist will, in turn, support the growth of the client. These comments seem obvious within the context of music therapy.

Bilton *et al.* argued that feelings of meaninglessness, isolation and powerlessness inhibit growth and decreases possibilities for action but they were not writing about the client, therapist or therapist-client relationship.²⁵ They were describing professions. Issues such as constant pressures from external authorities, an inability to influence managerial or strategic

²¹Erkkilä, Jaakko, Review: *Contemporary Voices in Music Therapy. Communication, Culture and Community*, eds. Carolyn Kenny and Brynjulf Stige (Oslo: Unipubforlag, 2003) (25.2.2003) see the website http://www.njmt.no/bookreview_2003029.html [part of an online discussion in an electronic journal on a website], p.3

²²Ibid., p.4

²³Priestley, Mary, *Music therapy in action* (London: Constable, 1975), p.15

²⁴Ruud, *Music Therapy: Improvisation, Communication, and Culture* (1998), p.3

²⁵See Bilton, Tony, Bonnett, Kevin, Jones, Philip, Stanworth, Michelle, Sheard, Ken, and Webster, Andrew, *Introductory Sociology*, 2nd edition (Basingstoke: Macmillan, 1987), p.458

planning, a lack of control over employment issues as well as a lack of a sense of belonging within a work situation all contribute to professional tensions and these are all issues which have been tackled through the process of professionalisation by the APMT.

The process of professionalisation has been treated with suspicion in recent years. In this dissertation I have attempted to redress the balance, and I would suggest a future area of research would be the extent to which the development of the discipline of music therapy works with the effects of the process of professionalisation. Perhaps it is time to address the question Bruscia asked in 1998:

Are theory, research, and clinical practice consistent with the public roles, titles, responsibilities, and standards that we adopt as a profession?²⁶

²⁶Bruscia, *Defining Music Therapy* (1998), p.14

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