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# Music Therapy Assisted Childbirth in the United States: A Critical Literature Review

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Music Therapy Assisted Childbirth in the United States: A Critical Literature Review

Capstone Thesis

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Music Therapy

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### **Abstract**

Music therapy assisted childbirth is an approach of music therapy in which a licensed and credentialed professional utilizes music therapy interventions to address a variety of goals during childbirth. There is a lack of literature and missing knowledge on the topic, associated with an increased rate in traumatic birth cases, mothers with post-traumatic stress disorder, and postpartum anxiety and depression. The literature review provides a summary of the historical context of feminist theory and feminism, as well as brief descriptions of music therapy, guided imagery and music, and familiar music interventions. One of the primary goals of this type of treatment is pain reduction. The focus of this literature review will primarily be to identify the efficacy of music therapy in reducing labor pain. Through the literature review, commonly used music therapy interventions for labor will be identified, as well as their effectiveness in managing pain, reducing anxiety, and promoting a positive birth experience. In order to do this, the history of feminism and feminist theory, music therapy practice, and obstetrics will be examined. Secondly, this literature review will address the accessibility of music therapy assisted childbirth within the United States.

## Music Therapy Assisted Childbirth in the United States: A Critical Literature Review

### Introduction

Those who experience labor without the assistance of pharmacological pain management methods will not only experience pain, but potentially anxiety, fear, and depression (Tinti and Businaro, 2011). Traditionally, in western culture, the medical professional present will suggest drug intervention for assistance with pain during childbirth. This may include an epidural or oral medication. However, with more recent waves of feminism (particularly the second and third waves), women are advocating for their rights to have a natural childbirth with no pharmacological intervention. Furthermore, such advocacy has shaped a new birthing culture. Women are beginning to request the assistance of mental health professionals to aid in the relief of pain as well as establish positive coping strategies. One such approach that shows signs of potential with pain and anxiety is music therapy. Women who receive music therapy during labor report feeling less fatigued, less anxious, and more in control of their experience. They also reported and observed as experiencing significantly less pain (Fulton, 2005).

Music therapy assisted childbirth is a method of music therapy in which a certified music therapist uses musical interventions to relieve anxiety and pain during and after childbirth. These interventions can be used alongside pharmacological pain management methods, administered by healthcare professionals. This method of music therapy can be provided as either short term or long term. The music therapist is present for the birth. Without the full presence of the mental health professional, the client may feel lost or unheard. Music played during the birth may include music familiar to the client (as agreed upon between therapist and client at an earlier date). Although the act of playing familiar music for a client may appear as a passive intervention, it requires the full attention of the therapist. Alternatively, the therapist and client

may choose to utilize guided imagery and music (GIM) methods of music therapy during birth. The role of the therapist is active in terms of remaining present and engaged with the client, while modulating interventions in the moment to match physical, mental, and emotional status of the client. This literature review explores both types of music therapy methods during labor. It will also use evidence in the literature to distinguish between the use of these methods in both short and long-term treatment, the goals, and the progression of what treatment may look like.

Music therapy assisted childbirth primarily aims to reduce pain and anxiety during the birthing process. Overall, goals of music therapy assisted childbirth are to 1) decrease pain during labor, 2) increase sense of control during childbirth, and 3) help clients advocate for their own treatment and needs within the healthcare field. These goals can be applied across both familiar music and GIM interventions.

Although the act of playing familiar music for a client may appear to be a subtle and passive intervention, it requires the full attention of the therapist. The therapist must know how to act accordingly in response to the client's changes in mood, pain, and anxiety. Ultimately, the role of the therapist is to create a container for pain and facilitate an experience of that pain. Within this container, the client can have the liberty of controlling and coping with the experience of pain and anxiety. This literature review examines the landscape of childbirth with a focus on assistance with pain in childbirth from a critical perspective, specifically focusing on the use of music therapy assisted childbirth as a potential approach.

### **Focuses of the Literature Review**

The focus of this literature review will be to examine both the importance and accessibility of music therapy assisted childbirth in the United States. This literature review aims to help contextualize the sociopolitical forces related to this issue, and how music therapists can

utilize the knowledge of these forces to create a container for clients. It will do so by examining the historical evolution of women's healthcare, obstetric practice norms, music therapy interventions, and outcomes of music therapy assisted childbirth studies. Feminist theory and its relation to this field of work will also be explored and discussed.

In order to discuss both the history of this issue and its relation to feminist theory, I will break up the historical discussion into three sections. Each will discuss its respective wave of feminism, as each new wave brought with it differing views of women's healthcare and childbirth practices. Each will also discuss the prevalence of music therapy within childbirth practice at the time. Within each of the three parts, methods of pain management, cultural norms, and female opinions on healthcare will be discussed. This will allow for the natural evolution of feminism, music therapy, and women's healthcare to unfold chronologically. Additionally, each section will include the history and prevalence of music therapy at the time, and the evolution of music therapy/music therapy assisted childbirth.

### **Limitations Observed**

It is necessary to note that much of the available research within this field focuses on women undergoing natural childbirth, as opposed to receiving a cesarean section. Women who undergo a cesarean section are placed on pain medication/numbing for the surgical procedure. This disqualifies women to participate in research within this particular field. Women who change their treatment plans and request pharmacological pain management interventions are also excluded from multiple studies. The literature available primarily featured within this thesis focuses on women undergoing natural childbirth (as opposed to cesarean section), and is written in English.

### **Literature Review**

Through a feminist lens, the healthcare field within the United States has historically been centered around white male culture (Massey, 2005). This has limited, and sometimes omitted, a woman's understanding and insight into her body and health. Upon examining past medical research/literature on the female anatomy and childbirth, illustrations depict both the inside and outside of the body. The exterior is portrayed as a more detailed, hypersexualized image. When created, these images were targeted at the male reader. With these types of images as the foundation for female medical treatment, it can be argued that the discourse of women's health rights has been shaped around the female as object, for the use of male experience and education (Massey, 2005).

### **Women in Obstetrics**

Cahill suggested that the exclusion of women from medical academia in the past three centuries stems from the Catholic church. The church believed that women were beings who practiced witchcraft. Those who practiced witchcraft were believed to have healing powers. Those considered witches were often present during childbirth so as to provide a "safe" and healthy birth experience. In an attempt to control the alleged presence of witchcraft from women in labor, men decided to become the primary presence during labor, which in turn omitted the female voice from academia (Cahill, 2000). Midwifery soon became a common aspect of childbirth, and evolved into an intellectual, academic, and professional field. Amidst this transitional period for midwifery, males assumed the roles of medical professionals, particularly in the field of obstetrics. As males dominated the field through higher education, midwives continued working based on experience and generational knowledge. Males brought forth the

idea that knowledge was superior to experience, and that knowledge would inherently be male, while empathy and experience would be inherently female (Cahill, 2000).

### **Midwifery**

Within the resources to be discussed within this literature review, the terms midwife and midwifery will consistently be referenced.

The word *midwife* is literally translated *with woman*. A regulatory definition of the midwife is endorsed by the International Confederation of Midwives (ICM), the World Health Organization (WHO) and the International Federation of Gynecology and Obstetrics (FIGO): ‘the midwife is recognised as a responsible and accountable professional who works in partnership with women to give necessary support, care, and advice during pregnancy, labour, and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and infant’ (Borrelli, 2014, p. 4).

Midwifery is an international practice, in which a trained and credentialed midwife aids in the birthing process to provide care, information, and support to a woman during her pregnancy, labor, and postpartum experience. Borrelli notes that there are domains through which a midwife must practice that qualifies her to be a “good” midwife. These include the affective domain (kind, supporting, compassionate), the cognitive domain (knowledgeable about pregnancy, labor, and postpartum experiences) and the psychomotor domain (being skillful at aiding during labor and pregnancy) (2014, p. 5).

It is important to understand the function and importance of having a midwife present for some people giving birth. Based off of the above definition/description of a midwife/midwifery, the presence and assistance of a midwife can aid in fostering a positive birthing experience,



reducing anxiety/pain, and increasing knowledge of pregnancy, labor, and postpartum experiences.

### **Doulas**

A concise and widely accepted definition of a doula does not currently exist. Although not all doulas are certified by a regimented or accredited program, there are registered and certified doulas who are paid for their work (Meadow, 2014). The existence of the doula dates to the early 20th century, where a doula (most often a woman during that time period) would be present so that the woman in labor would not be isolated from friends and family. However, many definitions stress the role of a doula being emotionally and physically supportive.

Physical support techniques include identifying helpful positioning for pain relief or labour progress, use of the breath, sacral counterpressure, and application of cold and heat. Doulas offer emotional support through techniques such as reflective listening, empathy, encouragement, mirroring and protecting an atmosphere of quiet focus. Many definitions of the doula role also encompass informational support and advocacy (Meadow, 2014, p. 3058).

A doula is similar to a midwife in that they provide support from pregnancy to birth. However, a doula focuses primarily on emotional support, as opposed to physical or educational.

Additionally, a doula may not provide postpartum support. A doula provides coaching throughout the birthing process, and will aid in advocacy for the mother's rights to comfort and support during labor.

### **First Wave of Feminism and Childbirth**

The first feminist wave, although arguably starting sooner, is most often reported to have begun about a century ago. During the first wave of feminism, women became more vocal

regarding lack of control over their own birth. They demanded better pain management resources, including opium, chloroform, or diethyl ether. A method known as “twilight sleep” was later developed, which was a combination of morphine and scopolamine. This method became known for its adverse side effects and was eventually discontinued. Although some of the mentioned methods are continually used, others were discontinued due to mother or infant death during childbirth. Epidural analgesia was invented during the first wave of feminism, popularized by Spanish military surgeon Pages. It was then popularized by Bonica, an anesthesiologist. Its primary use was for soldiers in the 1940s. Bonica had used the epidural on his wife during labor and noted that it aided in her childbirth process (Skowronski, 2015).

### **Second Wave of Feminism and Childbirth**

The second wave of feminism was from the 1960’s to the 1990’s. Lamaze classes were coming into fashion. At this time, women began to further voice their opinions on childbirth as a natural practice. Women expressed the want to have a more organic childbirth experience. Within this span of three decades, the rate of hospital births within the United States and United Kingdom was at 98% (Cahill, 2001). This included both vaginal delivery and cesarean section. It became the norm to seek professional medical assistance, outside the home, to give birth. Hospitals and maternity units advertised their services, promising a safe and healthy birth experience. However, many hospitals and medical professionals gave mother's little to no say in their treatment.

### **Third Wave of Feminism and Childbirth**

The third wave of feminism has extended from the 1990’s to today. It has become commonplace for women to request no pharmacological interventions for pain. Within the United States, Lamaze classes became popular as a form of birth preparation and education. With

this, midwives and doulas once again became prominent figures in the obstetric field. Recently, mothers have transitioned from having hospital births to home births, water births, and all-natural births. Third-wave feminists argue that there should be equality between all mothers. Despite the use or absence of pain medication during labor, mothers are all equal, and cannot be determined to be more or less of a woman for their decisions (Skowronski, 2015).

### **Male Influences in Medicine**

During the 1980's and 1990's, the practice of cesarean section was considered primarily a western practice. Labor was often wrongfully induced, which led to emergency cesarean sections. In response, women expressed feeling as though their ability to give birth naturally was diminished by male medical practitioners. However, the need for medical services during birth slowly pushed midwives out of mainstream hospital work. Cahill (2001) reported that women historically have had limited decision-making opportunities when it came to their maternal care. The dichotomy of primarily male medical professionals and mother created an inherently gendered hierarchy. The hierarchy led women to believe that men know more about the female body than the mother does of her own (Cahill, 2001). Although there are high-risk pregnancies that require medical intervention, Cahill suggested that not all women require the assistance of a medical doctor to successfully and safely give birth.

On the forefront of third-wave feminism is the argument that technology and medical sciences are inherently male. If a woman has chosen to give birth with medical intervention, it may be interpreted as her succumbing to the patriarchy, or going against her natural self. However, feminists in the third wave ultimately defend the idea that technology and medical sciences are not inherently gendered. Many women can benefit from, and require the assistance

of medical professionals to ensure the wellbeing of both themselves and their unborn child (Skowronski, 2015).

The obstetrician at the forefront of this movement, Dick-Read, argued that western women were becoming desensitized to pain. Additionally, he argued that pain was amplified by fear of having and experiencing pain itself. Women needed to overcome fear and embrace the pain as natural and empowering (Skowronski, 2015). At that time, women argued it was their right to undergo childbirth without requiring drug intervention. Women embraced what Dick-Read said, and began to transition into natural home births with the assistance of midwives and doulas. In addition, midwives began to seek independence from their male counterparts in the medical setting and offered their services individually to mothers.

### **Mother Identity and Mental Health**

Women are differentiated in literature as either nulliparous, primiparous, or multiparous mothers. Nulliparous is a mother who has never had a child previously. A primiparous mother is one who has had one child previously. A multiparous mother is one who has had more than one child previous to the current pregnancy (Miquelutti, Cecatti, and Makuch, 2013). Research within the field commonly focuses on primiparous or nulliparous mothers and their childbirth experiences. However, there is available research that focuses either solely on nulliparous/primiparous or multiparous mothers. For the sake of inclusivity, the literature discussed will not focus on one population over the other.

Whether a woman has children previously can be a determining factor for levels of pain experienced, feelings of control, and knowledge/education regarding the process. If a woman has previously given birth (primiparous or multiparous), she may have a better understanding about pain levels, norms, and coping strategies. A woman who has never previously given birth

(nulliparous) may have no education on the process. There has, however, been no direct link between nulliparous/primiparous women and prevalence of postpartum depression or anxiety.

### **Pain, Anxiety, and Control During Childbirth**

There are a multitude of factors that contribute to a mother's perceived control during labor, including stress, anxiety, fatigue, maternal conditions (i.e. preeclampsia), and utilization of labor inducing procedures (Fulton, 2005). These factors not only foster a negative birthing experience but may cause significant psychological harm long-term (Bonica, 1994). Escott, Spiby, Slade and Fraser (2003) believed that allowing women to develop positive, individualized and familiar coping strategies could marginally increase the satisfaction of a woman's birth experience, as well as lessen the prevalence of anxiety, stress, and fatigue. Fraser suggested that although women may already have established coping strategies for their birth, it may be effective for them to work with a professional to establish a wider variety of them (2003).

### **Pain, Anxiety and Childbirth**

In the study by Tinti, Schmidt, and Businaro (2011), women rated their pain and anxiety levels immediately and six months postpartum. These levels were rated on a seven-point Likert scale. Women interviewed directly after their birth were more likely to rate their pain levels as higher, and sense of control as lower. Upon interview six months postpartum, pain levels were rated as lower, and sense of control as higher. This change in ratings was possibly attributed to heightened anxiety and fear during and immediately after the birthing experience (2011).

Pharmacological pain management interventions have been linked with mild to moderate side effects, such as lasting back pain or grogginess. The prevalence of back pain after undergoing an epidural has been the most widespread complaint. Butler and Fuller discussed the prevalence of back pain post-epidural in the United States and United Kingdom. Through

postpartum interviews by phone, women reported continuing to feel localized pain 7-14 days after the procedure. Although uncommon, women may experience pain for two or more weeks after the procedure, and must seek further medical treatment (Butler & Fuller, 1998). Back pain after an epidural was negatively correlated with first-time mothers. Nulliparous women reported shorter duration for back pain after an epidural (1998).

Bonica (1979) discusses what is known as the gate control theory of pain. This theory discusses the experience of pain having the potential to be blocked before making its way through the central nervous system. This central nervous system is comprised of the spinal cord, brain stem, and cerebral cortex. This pain message or stimulus could potentially be stopped using a distraction method, one of which being music.

The gate-control theory emphasizes the need for a supportive environment allowing the laboring women to use the various higher mental activities, of which listening to music can be included, to decrease her perception of the pain of labor (Keever & Shepherd, 1991, p. 5).

Keever and Shepherd (1991) conducted a study in which they explored the effects of music on perceived pain during labor. In this study, participants (women actively in labor) selected pre-recorded music from four different genres to be played during the first stage of their labor (p. 29). They found that the use of music during labor decreased overall pain perception. Their results yielded partial support of their initial theory, in which music would be a successful medium of distraction to alleviate pain (p. 34).

### **Control and Childbirth**

With sufficient education and control over the birthing experience, a woman will be more satisfied with her birth (Miquelutti, Cecatti, and Makuch, 2013). This education may come from

an open dialogue between medical professionals and client, or a birth preparation program (BPP). A BPP is a series of classes in which a woman receives education regarding what to expect during birth, common terms used, and information on how a mother can care for herself throughout the process. Overall, a BPP aims to enhance the quality of the birthing experience to reduce the amount of traumatic birth cases. A woman's childbirth experience can be viewed as traumatic if not given the proper education and information. When a woman receives proper education regarding the childbirth process, she may feel as though she has more control over her treatment and her body (Skowronski, 2015).

Additionally, the study by Mccrea, Wright and Stringer (2000) utilizes a Likert scale to outline women's opinions regarding pain management, anxiety, and sense of control during childbirth. Women reported feeling a heightened sense of control and lessened anxiety when provided with proper education regarding the birthing process. When women experienced more control and less anxiety during birth, they reported being more aware of their emotions. These results aided in making informed decisions regarding their pain management. Women also reported that having the information to make an informed decision may have led them to choose alternative forms of pain management (that is, those other than oral medication or epidural).

Literature reveals that there is a culture of knowledge sharing through intergenerational narratives between female family members. Women receive advice or information on giving birth from female family members or friends; primarily those who have previously given birth. This information can prove to be educational and allow women to broaden their horizons of coping strategies for pain and anxiety. However, as each birth experience is unique, manifestation of anxiety and experience of pain is individualized. It is beneficial for the mother

to work with a third party (preferably a mental health professional) in order to distinguish a “normal” experience and how best to cope.

Keever and Shepherd discussed that “women who take an active role in the birth process have a decreased dependency on others and an increased sense of mastery and self-confidence” (1991, p. 36). A woman’s active role in her birth process is a key component in fostering a sense of control during labor. This control can be addressed through pregnancy, active labor, and postpartum treatment. Keever and Shepherd believe that having a sense of control and feeling prepared and active within the birthing experience aid in a woman’s self-confidence.

### **Alternative Nonpharmacological Pain Management Methods**

Other common methods of nonpharmacological pain management for women in labor include massage, nerve stimulation, hypnosis acupuncture, or aromatherapy (Fulton, 2005). Aside from alleviating unwanted side effects from drug intervention, women choose alternative pain management for its spiritual and cultural aspects, fair prices, and ease of use. Fulton noted that alternative pain management methods are reportedly not as effective in relieving pain. However, that does not denote the importance of alternative pain management. Fulton described using music during childbirth as a means of fostering a positive view on motherhood, inducing relaxation, preparing for birth, and reducing pain and anxiety (2005).

According to Cyna, McAuliffe, and Andrew (2004), “Psychological interventions such as continuous support during labor are associated with a reduced requirement for intrapartum analgesia, a lower incidence of operative birth, and reduced reports of dissatisfaction with childbirth experiences” (p. 505). This study examined the birth experience of 8,395 women and examined their use of hypnosis along with the outcomes of said nonpharmacological intervention. According to this study, hypnosis is a successful nonpharmacological intervention



used during labor to reduce anxiety and pain. The authors state “hypnosis has been utilized effectively where epidural analgesia is contraindicated and is claimed to block all subjective perceptions of pain during labor in up to 25% of parturients” (2004, p. 506). In addition, Cyna, McAuliffe, and Andrew reported that a secondary benefit of hypnosis during childbirth was a significant decrease in length of the first stage of labor. The study linked the reduced analgesic consumption during childbirth and hypnosis to patient autonomy (having a sense of control over the process), relaxation and reduced apprehension, and reduction of hyperstimulation of the uterus (2004). However, it must be noted that hypnosis only has these effects on those participants who are receptive to the idea of hypnosis.

### **Expressive Therapies and Childbirth**

There is currently limited research available regarding the overall field of expressive therapies and its use during childbirth. Much of the literature available addresses prenatal or postnatal treatment of anxiety, depression, or pain with the use of expressive therapies. There was no literature revealed that uses modalities other than music during active labor.

#### **Drama Therapy**

Karabekir defined psychodrama as the integration of sociological, philosophical, and psychological theories in order to rediscover spontaneity and creativity (2016). The article explored a program in Turkey known as Birth With No Regrets. This weekend birth preparation course addressed the process of birth, the act of birth as creativity, and the transcendental roles of both mother and baby. Within the weekend courses, psychodrama was utilized to enact the birth process. This not only served as an educational experience for parents, but established positive memories and coping mechanisms for when the actual birth happens. Karabekir explained that the parents were educated on the muscles involved in birth, and then experimented in a role-play,

acting as those muscles, the baby, and themselves. This way, they gained practical knowledge on the physical birth process, with tools to be able to recall this roleplay during the birth.

In this group, participants were able to roleplay and workshop potential ethical dilemmas that may arise during the process of pregnancy and childbirth (2016). Although this primarily addressed those in the class who worked as medical professionals, doulas, nurses, or midwives, it gave parents insight into the complexities of the professions and how to address issues if they arose.

### **Expressive Arts Therapy and Writing**

A study by Blasio, Camisasca, Caravita, Ionio, Milani, and Valtolina (2015) examined what preventative measures could be taken to prevent or reduce likelihood of a mother developing postpartum anxiety and/or depression. They examined the use of expressive writing as a means of expressing fears and/or troubling events as related to their birth experience. The authors noted that their research revealed writing about stressful and negative experiences aids with emotional regulation, self-observation, and a sense of control (2015, p. 861). The women who participated in this study were asked to write about their emotional connections to childbirth and labor.

The results provided evidence that women assigned to write about their deepest thoughts and feelings related to childbirth, compared to those assigned to write about non-emotional topics, reported at follow-up less global distress (total depression and PTS symptoms). In addition, significant interactions between group and baseline scores (total depression and PTS) were found at follow up. The nature of this interaction for the depression suggests that writing about deepest emotions in the narrative task may be

helpful in reducing symptoms for women with high and mean levels of depression but not for those with low depression (Blasio et. al., 2015, p. 871).

Expressive writing acts as a form of emotional processing. The women who participated in this study used the expressive writing in order to process their existing emotions surrounding their birth experience or biases, and were able to further examine their writing and experience.

### **Music Therapy Assisted Childbirth**

The Bonny Method of Guided Imagery and Music (BMGIM) is described as a form of healing, self-actualization, and therapy in which a guide (or therapist) dialogues during music, discussing imagery that appears for the client during an altered state of consciousness (Bruscia, 1998). Therapists may choose to implement the BMGIM method of music therapy in order to facilitate a sense of relaxation and comfort for the client. The therapist and client may choose to utilize BMGIM before, during, and after childbirth. A music therapist may choose to meet with the client before birth in order to establish a relationship, determine coping mechanisms, and discuss concerns regarding childbirth. Meeting after the birth would also be effective in managing pain, as well as processing the childbirth experience through BMGIM.

### **Guided Imagery**

According to Cyna, McAuliffe, and Andrew (2004) women who engaged in hypnosis and/or guided imagery during labor required less pain medication and experienced less pain than those without intervention. Additionally, Naparstek (2007) states that guided imagery helps focus on the birthing process, and can help resurface what has been learned from birthing classes, BPP, or other modes of coaching. Guided imagery is accessible, cost effective, and requires no previous experience from the client by any means (2007). Ultimately, guided imagery can aid in the process of preparing the woman for the transition into motherhood, which

Naparstek states is a powerful phase of life, a path that has been walked by countless women (2007).

Naparstek states “Music, when properly chosen, will increase the potency of imagery. People intuitively know what music is right for them. A small percentage of people prefer no music at all, especially if they know a lot about music or are extremely sensitive to/critical of it” (2007). It is necessary to note that guided imagery interventions are not always used with music, as it can sometimes prove to be a distraction for clients. However, Naparstek believes that music can amplify imagery if chosen with careful consideration.

### **Familiar Music**

Another common intervention used by music therapists during labor is playing of familiar music. Although this can be a playlist of pre-recorded music, it is both more efficient and effective to have the music therapist play this music live. If the music therapist plays the songs live, they are able to change tempo, tone, and dynamics in relation to what is happening with the mother either physically, mentally, or emotionally. In a study by Gonzalez (1989), couples experienced a music therapy assisted childbirth program for the birth of their children in a hospital. Couples would meet with the credentialed professional for several weeks before the due date, and establish playlists for different stages of labor, perceived needs during childbirth, and to foster relaxation and breathing (p. 114). These playlists were distributed at the time of birth. As the music therapist was not allowed in the room at that time, the significant other was trained in administering the playlists at the appropriate time. Gonzalez notes that even the medical professionals present for the birth were able to notice and appreciate the usefulness of the music for the specific experience of each client (p. 116).

### **Music Therapy and Feminist Theory**

According to Hadley (2006), a therapist who works through a feminist lens must be aware that every female's experience is different and must be knowledgeable on the impacts of male oppression and biopsychosocial factors on the experiences of clients.

Music therapy is part of the evolution of cultural values, including gender norms and values. It is not an oasis from cultural construction. My feminist perspective asserts that we are accountable and responsible because of our societal position. If we do not actively work toward systematic change, represented in our own interactions as well as our institutional policies and procedures, clients will be offered a small helping of the human potential for change (Hadley, 2006, p. 51).

The practice of music therapy assisted childbirth relates to feminist theory in that it incorporates the building of advocacy for women's equal rights. Particularly, music therapy assisted childbirth allows women to advocate for themselves, feel empowered, and take control of their own healthcare. Music therapists can use their position in order to facilitate a client's understanding of their own rights, the biopsychosocial factors that relate to oppression they experience, and how to further systematic change.

### **Secondary Benefits to Music Therapy Assisted Childbirth**

When music is utilized during birth, it may also have positive effects on the fetus. Fulton reports, in a study by Kisilevsky, Hains, Jacquet, Granier-Deferre and Lecanuet (2004), that the fetus is able to maintain a steady heartbeat when listening to music. This may be another important factor in maintaining control for the mother. When she knows that her unborn child is safe and healthy, she may experience less anxiety, fear, and agitation.

Naparstek notes that once the baby has been born, the use of guided imagery and music can promote bonding between mother and child (2007). Guided imagery and music can help mother and baby form a line of nonverbal communication and understanding. Auditory senses are the first to develop in the womb, and the use of music that may be familiar to the mother and baby helps in bonding, feeding, and regulation of vitals.

### **Discussion**

This literature review aimed to explore the effectiveness of music therapy assisted childbirth. It also aimed to explore the accessibility of music therapy for women in labor, through either at-home births or hospital births. This review was to be explored through a critical analysis of the available literature regarding pain management, birth, and nonpharmacological pain management methods for childbirth. The resources used within this literature review reflect the evolution of the field of both obstetrics and music therapy, as well as the progression of feminism in relation to women's health and mental wellness. According to Blasio, Camisasca, Caravita, Ionio, Milani, and Valtolina (2015), one in three women in the United States views her birth as anxiety-inducing or traumatic (p. 857). This leaves women at a higher risk for developing postpartum anxiety, depression or PTSD/PTS (posttraumatic symptoms). However, if proper education regarding the birthing process is available, as well as sufficient mental/emotional support during birth, the prevalence of such diagnoses could be significantly reduced. With the use of nonpharmacological interventions such as music therapy before, during, and after birth, as well as birth preparation plans, the statistics of postpartum anxiety and depression would be lowered.

## **Overall Findings**

Music therapy assisted childbirth has the potential to become a significant approach in relieving labor pain. Music acts as a distraction, a calming agent, and a natural analgesic. Music therapy interventions, with the aid of a licensed clinician can aid in establishing positive coping mechanisms, creating a container, and providing mental/emotional support for the mother and her loved ones. Music therapy as a method of pain management during labor can be utilized either in a hospital or for at-home births, depending upon the location of the therapist. Music therapy approaches that are most commonly used include BMGIM (The Bonny Method of Guided Imagery and Music) and playing familiar songs. Both approaches address goals of pain management and anxiety reduction. The field of music therapy assisted childbirth lends itself to feminist theory, and should continue to aid in the bettering of women's healthcare.

The findings from this research have revealed three major areas of clinical practice for a music therapist to consider when working in this population. The areas include pain management/reduction, anxiety management/reduction, and establishing sense of control/freedom. Additionally, the literature revealed that certain music therapy techniques are suited to fit the needs of this population. These techniques include Bonny Method of Guided Imagery and Music (BMGIM) and playing of preferred/familiar music.

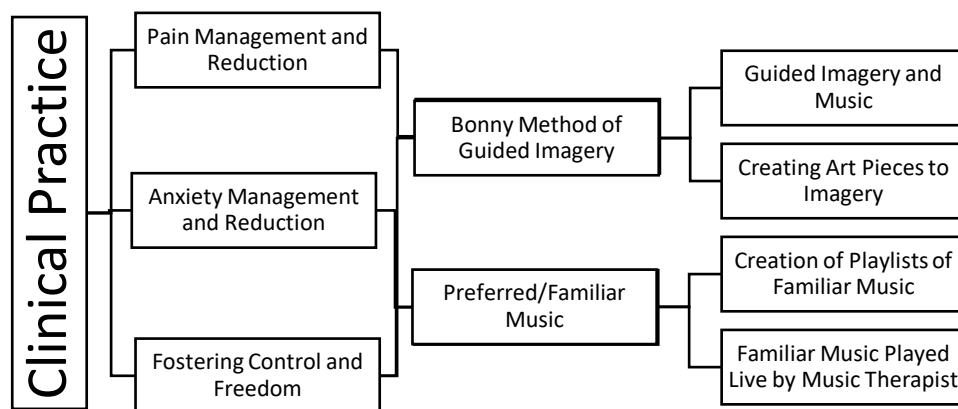
## **Translating Findings Into Clinical Practice**

Taken together, these findings support the consideration of a potential clinical framework for music therapists to consider. As seen in Table 1, pain management and reduction, anxiety management and reduction, and sense of control/freedom are three of the main domains that can be taken away from the accumulation of research. All three of these domains can be addressed using two primary music therapy techniques. These techniques include the Bonny Method of

Guided Imagery (BMGIM) and the playing of preferred/familiar music. From each of these techniques, a music therapist may choose to implement the following interventions. These interventions are general suggestions for how a music therapist might approach working with a client through the lens of each music therapy technique. From the research within this literature review, I believe these domains can be addressed prior to, during, and after childbirth/active labor.

Table 1

*Clinical Framework of Music Therapy Assisted Childbirth*



### Contributions to the Field

Through this literature review, a relationship between lessened perceived pain and anxiety during childbirth and the use of music therapy assisted childbirth/music therapy interventions has been identified. The accumulation of this research gives professionals a better understanding of both the scientific basis of music therapy, but also the growth and evolution of holistic healing methods.

According to Keever and Shepherd, this continued research can help increase the amount of families for which music therapists provide this type of service.



Clinically, the use of music as a pain reduction strategy in the setting of labor and delivery is particularly appealing because it is nonintrusive, economical, and generally pleasing to families of childbearing age. If music can provide the benefits of increased relaxation, and therefore decreased pain perception, its use for those who are not able to receive the benefits of prepared childbirth is critical (1991, p. 36).

For many, the access to a prepared childbirth is not an option. This may be due to geographical location, availability of competent services nearby, or economic status. The use and further research of this field can aid in reaching a wider variety of clientele for music therapists. The availability of these services will provide a more detailed array of research within the field in regard to economic status and/or cultural background of clients.

### **Recommendations for Further Research**

More recent research must be done on the physiological effectiveness of music therapy assisted childbirth. Much of the research used, even within this literature review, is dated as one to two decades old. Advancements in both technology and the medical sciences call for more updated research within the related fields, including mental health care.

There also must be more education on the field of music therapy assisted childbirth within accredited music therapy programs. I believe the current literature lends itself to further research into the connections between pain management and music therapy interventions. A lack of research on the field may identify a lack of knowledge on music therapy assisted childbirth, as well as a lack of distributed information to the future generations of music therapists.

The lack of research may also identify a lack of accessibility for music therapy services for childbirth. Ultimately, an aim of this literature review was to identify accessibility to music therapy services for women in labor. No official data was unveiled in regard to how accessible

these services are across age range, geographic location, maternal identity, etc. Future research should address differences in accessibility between rural and urban areas, nationally and globally.

In addition, more arts-based research regarding the field of music therapy assisted childbirth should be written. Much literature that exists within this field is a combination of both qualitative and quantitative research. Although this research is helpful in upholding the scientific credibility of music therapy, it requires a more artistic basis to be relevant across all modalities within the expressive therapies profession.

It must also be noted that there is a lack of literature regarding the practice of music therapy assisted childbirth used with a variety of cultures, ethnic backgrounds, and religious beliefs. Thus, there have been no correlations made between the use of music therapy assisted childbirth for pain and cultural birth practices. The available literature, particularly that used in this literature review, does not identify cultural backgrounds or birthing norms of other cultures or ethnicities. In order to establish this practice as more widely accepted, it requires a more well-rounded and culturally sensitive variety in literature. That being said, the idea that various cultures may be more private about childbirth must also be considered. Despite culture, birth is an individualized experience, and may be considered intimate to the mother. None of the research found has discussed the intricacies of the birthing process and how delicately the research should be conducted. It cannot be assumed that all mothers wish to partake in a more holistic or natural approach to their birth, and research should reflect this.

## **Conclusions**

Music therapy assisted childbirth should be considered as a successful mode of nonpharmacological pain management and anxiety reduction for women in labor. Music therapy

interventions have the potential to avert attention from pain, establish positive coping mechanisms, and be used for continued care of both mother and baby. Despite a field of growing research on nonpharmacological pain management within obstetrics, the literature on women's health, feminist theory, and music therapy continues to be limited.

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