

**PART THREE:  
MUSIC THERAPY IN THE  
AREA OF ATTACHMENT/  
COMMUNICATION AND  
DEVELOPMENTAL  
PROBLEMS FOR  
CHILDREN, ADOLESCENTS  
AND FAMILIES**

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[A reflexive introduction](#)

**Music therapy in work  
with attachment /  
communication and  
developmental problems  
for children / adolescents/  
families**

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In part three, we have organised our contributions in the form of six papers that link to the structure and content of the symposium. The three lecture papers will be presented in chronological order; this is then followed by the reflection papers which are based on the subsequent comments and discussion. The lecture papers were longer due to being based on the 'Why?' questions. Those responding to the questions had received the presenters' papers beforehand but were told to relate their comments to the papers and the 'Why?' questions more freely.

In order to communicate all of the contributions in a meaningful fashion (and as one consistent text) we have slightly revised some parts from the symposium by adding certain aspects and/or

leaving out others. We think, therefore, that it is more meaningful to hand over to you, the readers, the contributions as they generally occurred on that wonderful April day, which is as open dialogues between professionals with different and exciting perspectives on a sobering and complex topic.

From their own individual perspective, the paper presenters tried to answer and discuss the questions 'Why music?' and 'Why/When a music therapist?'. The respondents gave their further thoughts and perspectives on the matter and an additional range of pathways became evident. These are not easy questions and depending on the aim of the questions or, how you understand them, there are many different answers or directions to take. In relation to working with children, adolescents and families with different challenges and resources, some common characteristics do, however, emerge from these six music therapists. Empowering, participating, facilitating, and ensuring ethics and human rights seem to be important aspects when wanting to understand *why music* and *why and when a music therapist is relevant* within this particular field. Music, together with a facilitating music therapist, forms a unique medium to empower individuals and groups, to motivate and inspire participation and thereby ensure the human rights of individuals with developmental or 'at-risk' challenges.

## Lecture 1

### **Why music? Why and when is a music therapist needed?**

**Stine Lindahl Jacobsen**

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'Why music therapy?' What a broad and mysterious question! One might counter this and ask: 'Why do you want to know this?' Is it about arguing for music therapy or is it about trying to learn more about our field and sharing knowledge from within our field? My choice of discourse and use of words would be quite different depending on the answer to the latter question and in this presentation it will be a mix. To answer the question with the aim of arguing for music therapy, I could choose to step backwards and try to answer from a broad perspective by including thoughts around what music means to us as humans. I could look to music psychology and try to find answers in theory and in research studies. Yes, let's start here.

According to the anthropologist, Merriam (1964), music has many functions in our lives. It can be a way of expressing ourselves and our emotions either when singing in the shower or performing on an opera stage. Music holds the possibility for us to experience aesthetic enjoyment, we can be entertained and entertain others and it can facilitate communication between us when we talk about our experiences. Music can be a symbolic representation of, for instance, identity, such as when we sing the national anthem at sports events. Music often causes us to move; an example being when we tap our feet to the beat of the music. Music also enforces conformity to social norms like when we sing certain songs in certain settings, and music also validates social norms and religious rituals. Moreover, music can contribute to the continuity and stability of culture and it can even contribute to the individual's integration into society (Merriam 1964).

Depending on individual cultures in different

countries, these ten functions of music are all essential and relevant in using music to promote health and quality of life. Music can evoke emotions through reflexes in the brain such as conditioning, visual imagination and musical expectation (Juslin & Västfjäll 2008). Furthermore, research shows us how music can evoke and regulate emotion through subjective experiences, physiological arousal, bodily-emotional expressions and both visible and non-visible actions (Koelsch 2014).

A way of understanding the impact and potential of music in a health perspective is through a holistic view of man. Biologically, sound and timbre are vibrations that have a direct influence on the body. Psychologically, music is a language with syntax and semantics and therefore it speaks to us, and we can speak through it. Socially, music is an activity that can engage and connect us in smaller or larger communities; and existentially, music can enable us to experience deep non-verbal meaning (Bonde 2009). Building on this, music seems quite relevant to use when your aim is to promote health and empower individuals, groups, families and communities.

### Why a music therapist?

But how does society gain access to the powerful potentials of music when the aim is to promote health? The broad answer seems simple enough – through a discipline that consciously uses the functions and impact of music and that understands health and humans. Music therapy is this discipline. Music therapists understand music and understand man and they adjust a professional and therapeutic use of music to the individual needs and resources of the people they work with.

In research on the effect of music therapy a holistic view of man is evident. Looking across client groups biologically, music therapy has a positive effect on pulse and blood pressure, respiration, perception of pain, lung function and agitation (Bradt et al. 2010; Bradt & Dileo 2011; Bradt et al. 2011; Vink, Bruinsma & Scholten 2011). Psychosocially, music therapy has a positive effect on mental state, depression, anxiety, psychosis, initiative and mood (Bradt et al. 2011; Maratos et al. 2009; Mössler et al. 2011). Socially, music therapy has a positive effect on social interaction, non-verbal communication, social-emotional mutuality, social adaptation and parent-child relationship (Bradt et al. 2010; Geretsegger et al. 2014). From an

existential perspective, music therapy has a positive effect on quality of life, hope and spirituality (Bradt & Dileo 2011; Bradt et al. 2011). The broad perspective of research tells us how music therapy – which we presume includes a music therapist – is relevant as it has quite a range of positive effects for many different individuals and groups with specific challenges in relation to health.

### When is a music therapist needed?

To answer the question ‘*When is a music therapist needed?*’ I now choose to zoom in and be less broad in trying to answer the questions; my aim no longer solely being to argue for music therapy. So I zoom in on working with families in music therapy as I have recently co-edited a book on the topic, in which 14 different authors wrote about their specific approach and use of theory in working with families, ranging from parents and their premature infants to people with dementia and their caregivers (Jacobsen & Thompson 2016). In each individual chapter, these experienced authors discuss their role as a music therapist where despite the differences of approach, some common characteristics also emerge.

A resource-oriented and family-centred approach is common throughout the chapters in which music therapists strive to empower the families to meet their own challenges. The therapist partners with the family in trying to help find useful pathways to positive change and promotion of health. Many authors also have a systemic and solution-oriented approach where everyone in the family is welcomed into being a part of the solution. The main focus is on competencies and resources rather than on problems, where change is considered constant and inevitable, and where meaning is negotiable. All family members’ expertise or lived experience is recognised and the therapist tries to assist them in finding their own inner resources and helps them to find ways to cope (Jacobsen & Thompson 2016a).

Different theories are presented in trying to understand the dynamics of family therapy and here the role of the therapist in music therapy also becomes evident. Affect attunement, attachment and communicative musicality are terms often used in explaining roles and approaches and the authors seem to be focused on being both a role model of how to interact, and a facilitator of building

relations. Role-modelling is about inspiring families to try out new ways of interacting and guiding families to find their ways. However, role-modelling how to perform 'good enough' affect attunement and how to match and communicate clearly is not without risks. The risk is to overshadow parents or to form unhealthy stronger relationships with some family members more than others, endangering the focus of wanting to empower the family and strengthen their coping abilities. Therefore, being aware of when to role-model and when to facilitate becomes crucial. You must know when to give room and let the family interact and let them grow stronger together without you being there to constantly guide them. You must know when being a facilitator is possible and to act upon it. For this you need a skilled therapist. In my perspective as a music therapist, you actually have an advantage when working with families as this difficult shift between needed roles can happen in the music, in which multiple roles are possible. Trondalen's vignette below in this same article is a perfect example of an event with a dynamic shift between being a role-model and being a facilitator. Her point is, however, slightly different than mine.

Nevertheless, my point is that music enables music therapists to dynamically shift between roles when working with families in a unique and empowering way. Music-making within music therapy, therefore, is especially powerful because the family system can become more flexible and open to change through music-making, thereby giving the music therapist a unique range of complex and customised ways to work towards the family's goals.

## References

- Aranda, K., & Hart, A. (2015). Developing resilience to tackle health and social inequalities. *Primary Health Care*, 25(10), 18-25.
- Bonde, L. O. (2009). *Musik og Menneske: Introduktion til Musikpsykologi*. Fredriksberg: Samfundslitteratur.
- Bradt, J. & Dileo, C. (2011). Music therapy for end-of-life care. Review. *Cochrane Database of Systematic Reviews*, 3, DOI: 10.1002/14651858.CD007169.pub3.
- Bradt, J., Dileo, C., Grocke, D. & Magill, L. (2011). Music interventions for improving psychological and physical outcomes in cancer patients. *Cochrane Database of Systematic Reviews*, 8, DOI: 10.1002/14651858.CD006911.pub2.
- Bradt, J., Magee, W.L., Dileo, C., Wheeler, B.L. & McGilloway, E. (2010). Music therapy for acquired brain injury. *Cochrane*

*Database of Systematic Reviews*, 7., DOI: 10.1002/14651858.CD006787.pub2.

- Jacobsen, S. L., & Thompson, G. (Eds.). (2016). *Music Therapy with Families: Therapeutic Approaches and Theoretical Perspectives*. London: Jessica Kingsley Publishers.
- Jacobsen, S. L., & Thompson, G. (2016a). Working with Families: Emerging Characteristics. In S. L. Jacobsen & G. Thompson (Eds.), *Therapeutic Approaches and Theoretical Perspectives* (pp. 310-327). London: Jessica Kingsley Publishers.
- Juslin, P., & Västfjäll, D. (2008). Emotional Responses to Music: Behavioural and Brain Sciences. In L. B. Meyer (Ed.), *Emotion and Meaning in Music* (pp. 559-621). Chicago, IL: University of Chicago Press.
- Koelsch, S. (2014). Brain correlates of music-evoked emotions. *Nature Reviews Neuroscience* 15, 170-180.
- Maratos, A., Gold, C., Wang, X. & Crawford, M. (2009). Music therapy for depression. *Cochrane Database of Systematic Reviews*, 1, DOI: 10.1002/14651858.CD004517.pub2
- Merriam, A. P. (1964). *The Anthropology of Music*. Chicago, IL: Northwestern University Press.
- Mössler, K., Chen, X., Heldal, T.O. & Gold, C. (2011). Music therapy for people with schizophrenia and schizophrenia-like disorders. *Cochrane Database of Systematic Reviews*, 12, DOI: 10.1002/14651858.CD004025.pub3
- Stern, D. N. (1995). *The Motherhood Constellation*. New York: Basic Books.
- Vink, A. C., Bruinsma, M. S. & Scholten, R. (2011). Music therapy for people with dementia. *Cochrane Database of Systematic Reviews*, 3, DOI: 10.1002/14651858.CD003477.pub2

## Lecture 2

# Music therapy as appreciative recognition for mothers and children within a child welfare programme

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The case illustration in the following vignette is drawn from a research project exploring group music therapy for mothers and children within the frame of a Child Welfare Programme. The group lasted for four months and the vignette is from the fifth session out of ten. Mothers and children gathered for group music therapy within the frame of a Child Welfare Programme (Trolldalen 1997).

Mothers and the children have been playing on the floor. One mother returned quickly to her chair. The rest of the group were still lying on the floor when the music therapist asked: "What can we do next?". One of the children said; "stand up". Everybody stood up and the music therapist said; "everybody can stand and hold each other's hand". Everybody was singing and dancing in a circle: "yes, we are dancing together now, dancing together now". After a short while (about 20 seconds) the music therapist changed the text to "dancing with mummy, dancing now" and moved herself over to the piano. The circles dissolved and the mother-and-child dyads were searching for each other. The mother at the chair moved towards her child when hearing the lyrics. The mothers and children danced as pairs. One of the children jumped up to his mother, who immediately lifted him up and swung him around. Shortly after all the mothers were raising up their children and swinging them high up in the air. The music therapist picked up the activity while singing: "swinging around, do it now, swinging around up high". Lots of laughter and fun.

## Why music?

Musical participation is a human right. The Universal Declaration of Human Rights (United Nations), article 27 (part 1) says: "Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits".<sup>7</sup>

Music is a way of communicating through an art form. In this example, the mothers and children sang, "yes, we are dancing together now, dancing together now". After a short while the music therapist changed the text to "dancing with mummy, dancing now" and moved herself over to the piano. The mothers and children continued playing together while singing.

Music is also an agent in itself. In this example, the music carries the activity forward and supports possibilities of participation. In addition, music becomes a field of exploration. The music offered a framework for the activity, while still promoting participation based on personal resources. Through music, the mother and child explored a joint intersubjective field (Trevarthen & Malloch 2000).

Music activates vitality, creativity and resources in a musical network. One of the children jumped up to her mother, who immediately raised her up and swung her around. Shortly after all the mothers were raising up *their* children and swinging them high up in the air. The musical vitality was contagious.

Additionally, music re-makes anew in the moment. One of the mothers said that she did not think she could participate because she did not play any instrument. But indeed she participated.

## When is a music therapist needed?

A music therapist can facilitate and support initiative and resources through musical actions. The present activity initiated from one child suggesting, "stand up". The music therapist recognised the idea, and offered a familiar melody and introduced the lyrics "dancing in a circle".

In addition, the music therapist offers a musical relationship in which to experience and explore

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<sup>7</sup> Downloaded from [http://www.ohchr.org/EN/UDHR/Documents/UDHR\\_Translations/eng.pdf](http://www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf)

oneself and others. Joining the music therapy group offered a renewed attentiveness (dancing together). The music therapist intentionally changed the lyrics to support the joining of dyads to “dancing with mummy”. All dyads joined the dancing.

The music therapist offers a musical, flexible and emotional framework for development. In the example, the music therapist recognised the initiatives of the pairs (“swinging around up high”) by giving these a musical form through rhythm, melody and text. From these musical actions, the dyads shared the joy of having their expectations fulfilled from the music therapist (“turn around one more time”).

### Why is a music therapist needed?

The music therapist recognises the mother and child through music experiences in music therapy practice, and in society at a more general level. I gave an example from a Child Welfare Programme. On this basis, I would like to draw attention to the philosopher Honneth’s (1995) three-part model of ‘*The Struggle for Recognition*’ in which a variety of perspectives are synthesised. His work is based on social-political and moral philosophy, especially relations of power, recognition, and respect. Honneth relates social and personal development to three phases of recognition: love, rights and solidarity.

The first phase in his model is linked to the primary relations, to the demand for love (emotional commitment). Everybody needs close relationships and the experience of love, as observed in the example above. Such a relationship confirms the dependability of one’s senses and needs. And it makes building blocks for self-esteem and self-confidence. The motherhood constellation (Stern 1995) is at stake, as in the present vignette.

Secondly, Honneth claimed the demands for rights, connected to the law. This phase relates to the recognition of others as independent human beings with equal rights like oneself (cognitive respect and self-respect). Everybody should have the right to participate in a music therapy group – including when the group is within the framework of the Child Welfare Services, where participants often feel/are oppressed or less fortunate.

The last phase, phase three, was the call for solidarity (i.e. social recognition, social value and life). Attending the music therapy group gave them

social status. When the mothers told others, for example, that they could not go to the cinema, because they had to participate in the *music* group, they experienced respect and curiosity – as attending and participating in music activities afforded a personal and social value in life. Through the music therapy group the mothers and children were recognised as individual and unique persons, which is at the very core of developing self-esteem. These three forms – love, rights and solidarity – are mutually influencing each other.

Many people, within the framework of Child Welfare Services have had bad experiences with inclusion and recognition. Some people tell about their loss of rights. Promoting a three-layered model of the struggle for recognition may encourage a renewed way of life interpretation, in which music therapy is seen as one way to support identity independent of economic and social status. Music then becomes a right everybody handles – a right to participate in a cultural community through music (Trondalen 2016b).

The meaning of music therapy is the meaning of a shared experience. As long as it is something that we can open up for and share with each other, such a shared life-world experience offers new competencies for life (Trondalen 2016a).

### References

- Honneth, A. (1995). *The Struggle for Recognition: The Moral Grammar of Social Conflicts* (Translated by J. Anderson). Cambridge: The MIT Press.
- Stern, D.N. (1995). *The Motherhood Constellation*. New York: Basic Books.
- Trevarthen, C., & Malloch, S. (2000). The dance of wellbeing: Defining the musical therapeutic effect. *Nordic Journal of Music Therapy*, 9(2), 3-17.
- Trolldalen, G. (1997). Music therapy and interplay: A music therapy project with mothers and children elucidated through the concept of “Appreciative Recognition”. *Nordic Journal of Music Therapy*, 6(1), 14-27.
- Trondalen, G. (2016a). *Relational Music Therapy: An Intersubjective Perspective*. Dallas, TX: Barcelona Publishers.
- Trondalen, G. (2016b). Musikkterapi som anerkjennelse. Om et mor-barn prosjekt innenfor rammen av barnevernet. In K. Stensæth, V. Krüger & S. Fuglestad (Eds.), *I transitt – mellom til og fra. Om musikk og deltagelse i barnevern* (pp. 107-126). Oslo: Centre for Music and Health.

## Lecture 3

# Calling for an anti-oppressive language for describing young people and families within music therapy discourse

**Katrina McFerran**

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Originally the topic for the roundtable discussion was named as children, adolescents and their families who have attachment, communication and developmental problems. My first response to this topic is to challenge language that relies on a deficit model which points to 'clients' who have 'problems' and whom the professional 'helps'. I believe this sets up a conflict of values between the ways that we describe the value of music therapy and the ways we practise, which are often strengths-oriented. Instead, I suggest that we would be better served to draw upon research, theory and United Nations conventions that suggest a more contemporary language and better reflect the kinds of relationships that we might experience in therapy with children, adolescents and families.

People with disabilities have been advocating for inclusion and respect for many years, as popularly referenced to in James Charlton's text *'Nothing About Us Without Us'* (Charlton 1998), which was an indictment on the disempowerment of people with disabilities by models that emphasise dependency and powerlessness. More recently, this has been formalised in the United Nations conventions, for example, in the convention on the Rights of Persons with Disabilities that clearly emphasises a social, rather than a medical model of understanding disability. In the preamble it states that:

"Recognizing that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full

and effective participation in society on an equal basis with others" (Point E).

"Emphasizing the importance of mainstreaming disability issues as an integral part of relevant strategies of sustainable development" (Point G).

"Recognizing the importance of accessibility to the physical, social, economic and cultural environment, to health and education and to information and communication, in enabling persons with disabilities to fully enjoy all human rights and fundamental freedoms" (Point V).

In addition, in Article 7 children with disabilities are clearly referenced and empowered by the following point:

"Children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children".

This notion of children having choices and being empowered to participate in their own growth and development is echoed in the Convention on the Rights of the Child (UN General Assembly 1989).

A recent special edition of *Voices: A World Forum for Music Therapy*, provided a wealth of perspectives on this topic. Sue Hadley's editorial (2014) provides context for the subsequent set of powerful articles that emphasise a more contemporary language and understanding of work in the field. Hadley summarises this by noting that this is "not a problem residing in an individual, but a problem residing in our collective societal understanding of norms and deviance and our lack of acceptance (and, at times, outward rejection) of human diversity".

This need for movement away from the use of labelling language that is embedded in an expert model is equally relevant in discussion of adolescents. For example, Kitty te Riele (Riele 2006) has suggested using the term 'marginalised' students to describe those young people who are currently called youth 'at risk' because their educational outcomes are low and they are at risk of not getting their education. By emphasising the systemic elements, it identifies that it is their relationship with schooling that should be addressed, not their personal characteristics. This approach allows recognition that marginalisation is at least in part a product of schools and society,

and requires action in those arenas.

Discourse on resilience has undertaken a similar turn in recent years, moving from theories about why some people were resilient towards more contextualised explanations. Instead of focusing solely on building the resilience within young people, researchers have begun to emphasise the interaction between people and their conditions (Aranda & Hart 2015). Michael Ungar's (2004) work has proposed that a more ecological perspective invites us to consider how gender, race, ability and a range of other factors come into play when we are determining both people's capacity and their access to support.

We may also choose to consider the label of 'problem music' as Adrian North has labelled it (North & Hargreaves 2006). This kind of labelling is in opposition to the ways that Tia De Nora (2013) has described how music affords certain possibilities, with power being retained by those doing the appropriating, not being placed in the object which is the music. I argue that using language which does not serve the empowerment of people whom we meet in music therapy sets up inherent contradictions between our practices and our words.

Instead of drawing on a deficit model that is incongruent with strengths-based values and incompatible with the ways that music works, I suggest that music therapists increase their relevance by embracing a social rather than a medical model. This has been embraced in Community Music Therapy discourse (Stige, Ansdell, Elefant & Pavlicevic 2010) as well the anti-oppressive position suggested by Sue Baines (2013). It has also been well-established by Randi Rolvsjord's (2010, 2014) work within the mental health arena, and Sue Hadley's (2014) critical perspective on music therapy from the perspective of disability studies. The field of adolescence would benefit from a similar reconsideration of language and understandings from a critical perspective.

If music therapists did adopt this perspective, I believe we would encourage a multi-theoretical, but contemporary perspective that may include:

- Creating mutually empowering conditions so that people can flourish (resource-oriented);
- Revealing the complexities of what music can help us understand (insight-oriented);
- Carrying responsibility by providing direction

and structure when necessary (supportive);

- Advocating and agitating for changes in the oppressive systems that see people in deficit and fail to celebrate the gifts of diversity (anti-oppressive).

## References

- Baines, S. (2013). Music therapy as an anti-oppressive practice. *The Arts in Psychotherapy, 40*(1), 1-5.
- Charlton, J.I. (1998). *Nothing About Us Without Us: Disability Oppression and Empowerment*. California: University of California Press.
- DeNora, T. (2013). *Music Asylums: Wellbeing through Music in Everyday Life*. Surrey: Ashgate.
- Hadley, S. (2014). Shifting frames: Are we really embracing human diversities? *Voices: A World Forum for Music Therapy, 14*(3). Retrieved from <https://voices.no/index.php/voices/article/view/801>
- Riele, K.T. (2006). Youth 'at risk': Further marginalising the marginalised. *Journal of Education Policy, 21*(2), 129-145.
- North, A.C., & Hargreaves, D.J. (2006). Problem music and self-harming. *Suicide and Life Threatening Behaviour, 36*(5), 582-590.
- Rolvsjord, R. (2010). *Resource-Oriented Music Therapy in Mental Health Care*. Gilsum, NH: Barcelona Publishers.
- Rolvsjord, R. (2014). What clients do to make music therapy work: A qualitative multiple case study in adult mental health care. *Nordic Journal of Music Therapy, 1-26*.
- Stige, B., Ansdell, G., Elefant, C., & Pavlicevic, M. (2010). *Where Music Helps: Community Music Therapy in Action and Reflection*. Farnham: Ashgate.
- UN General Assembly (1989). Convention on the Rights of the Child, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3. Retrieved from <http://www.refworld.org/docid/3ae6b38f0.html>
- Ungar, M. (2004). A constructionist discourse on resilience: Multiple contexts, multiple realities among at-risk children and youth. *Youth & Society, 35*(3), 341-365.



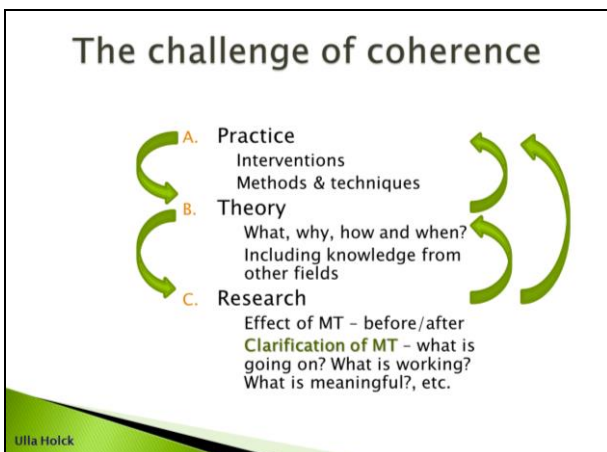
## Reflection paper 1

# Music therapy as profession: A need for coherence between practice, theory and research

**Ulla Holck**

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When discussing ‘*Why music?*’ and ‘*Why and when is a music therapist needed?*’, there is not one answer but many in the light of different contexts and approaches for practice. Whatever the chosen approach, however, there is a need for clear coherence between the chosen practice, theory and research, as illustrated in the figure below.



**Figure 1: The challenge of getting coherence between the practice, theory and research within music therapy<sup>8</sup>**

Katrina McFerran is referring to WHO’s conventions about the rights of people with disabilities, as well

as applying social theory and the research of power. Gro Trondalen is referring to the United Nations’ Declaration of Human Rights, as well as applying theories and research into early infant development and Honneth’s work focuses on social-political and moral philosophy. Stine Jacobsen is referring to a resource- and family-centred approach, including both system and attachment theory, and focusing on empowerment, self-efficacy and coping abilities. There are a lot of similarities to the goals, but when it comes to the music therapist’s role and the ‘*Why?*’ question, we see slightly different approaches linked to the different contexts.

As an example of trying to explicate the ‘*Why?*’ a music therapist is needed, Jacobsen told us about the commonalities in family approaches. In her PhD, Monika Geretsegger has done the same but has taken it a bit further, synthesising the practice and theory of improvisational music therapy with children with Autism Spectrum Disorder (ASD) across ten countries. This has resulted in treatment guidelines focusing on *unique and essential principles of music therapy within this group* (Geretsegger et al. 2015). Music therapy shares some essential principles with other relation-based interventions for children with ASD, such as to facilitate enjoyment and follow the child’s lead. What is unique in music therapy is the use of improvisational music to facilitate musical and emotional attunement, scaffold a flow of interaction musically, and to tap into a shared history of musical interaction (Geretsegger et al. 2015). By synthesising these unique principles, the guidelines point to the required improvisational and therapeutic skills needed for the music therapist to undertake what clinical practice and research has shown to be the most effective intervention for children with ASD.

Both Jacobsen and Trondalen mention early relationships. When working with young children or families this connection is quite obvious. But when discussing ‘*Why music?*’ it is evident that ‘*Communicative Musicality*’ comes before music for all of us (Malloch & Trevarthen 2009). This has given rise to interest among professionals from many different fields in the origin and significance of music, and especially the significance of communicative musicality in human interaction (Malloch & Trevarthen 2009). One answer to ‘*Why music?*’ and ‘*Why a music therapist?*’ for children with special needs could therefore be that a

<sup>8</sup> This figure was created by Holck (2014) for teaching in Music Therapy Theory and Research at Bachelor level, The Music Therapy Programme, Aalborg University.

musical amplification of the communicative musical qualities in early forms of interaction can help the child to perceive the initiatives of others as socially or cognitively meaningful (Holck 2002, 2004, 2015). Through music this can be done in a way that matches the age of the child and their musical cultural background.

## References

- Geretsegger, M., Elefant, C., Mössler, K.A., & Gold, C. (2014). Music therapy for people with autism spectrum disorder. *Cochrane Database of Systematic Reviews* (6). Art. No.: CD004381.
- Geretsegger, M., Holck, U., Carpenté, J., Elefant, C., Kim, J., & Gold, C. (2015). Common characteristics of improvisational approaches in music therapy for children with autism spectrum disorder: Developing treatment guidelines. *Journal of Music Therapy*, 52(2), 258-281.
- Holck, U. (2002). *Kommunikalsk samspil i musikterapi*. PhD Thesis, Aalborg University, Denmark.
- Holck, U. (2004). Interaction themes in music therapy: Definition and delimitation. *Nordic Journal of Music Therapy* 13(1), 3-19.
- Holck, U. (2015). Musikalsk leg med formgivning, timing og vitalitetsformer. Opbygning af fælles samspil med børn med autisme ved hjælp af musikterapeutiske teknikker. *Mellanrummet*, 32, 35-44. Retrieved from <http://www.mellanrummet.net/nr32-2015/artikel-musikalisklegmedformgivning.pdf>
- Malloch, S., & Trevarthen, C. (2009). Musicality: Communicating the Vitality and Interests of Life. In S. Malloch & C. Trevarthen (Eds.), *Communicative Musicality: Exploring the Basis of Human Companionship* (pp. 1-11). Oxford: Oxford University Press.

## Reflection paper 2

# Music therapy in work with attachment / communication and developmental problems for children / adolescents / families

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In my response to, and reflections on, these presentations I have chosen to focus on the question of 'Why is a music therapist needed?' as opposed to a community musician, or some other kind of therapist, in work with young children and families. I think the case for why music is needed has been well made, but perhaps some other kinds of musicians could also be using music for similar purposes. The practice of 'Music and Health' is fast developing. Within this, musicians also run music groups for parents and children who may have specific needs. So what is the difference between a music therapist and a community musician running this? Community music practitioners can be extremely skilled at developing musical interactions and bringing people together, at 'doing' music. They may be responding, however, to the music created with a different focus to that of a therapist. As demonstrated in Trondalen's examples, the music therapist is frequently responding to something other than simply the music.

I suggest that the music therapist has a specific way of listening that is different to other musicians in this kind of setting, and which informs her musical responses and how she moves the playing on. Where a community musician may be listening to the musical patterns of interactions, the music therapist is listening to the relational patterns heard within the music. So the aesthetic musical direction may be less foregrounded; the therapist facilitates the musical development informed by their understanding of the extra-musical meaning of the

music, and how this reflects the relational and attachment patterns.

For children such as those with learning disabilities, music therapy can provide a non-threatening way for parent and child to learn how to be together, which is qualitatively different to that of other interventions. An example from my own practice concerns the father of a three-year-old boy who has Down's syndrome and the difference in his understanding of aspects of communication through occupational therapy and music therapy. Participating in a multi-family music therapy group, the father was constantly frustrated with his son's apparent lack of response when given musical cues in the activities and action songs. After a time, I pointed out when his son did respond, which was just much later than the other children. The father then began to notice this for himself, and found that if he left a much longer pause in his music, his son did respond in the 'correct' place. He was very excited by this, exclaiming "that's what the occupational therapist keeps telling me, I don't wait long enough!" This was an issue of timing in his interactions, and it was only now, through experiencing this in the music that he understood and was able to adapt his behaviour and match his son's pace. So many elements of communication can be experienced through music in different ways to other therapies.

A further word on 'Why music?'. We have seen in the preceding presentations how the innate musicality of the child can be evoked, providing a way for the child to engage with the therapist and parent. This can also work in the opposite direction: the child, through their music, can call something forth from the parent, can bring out the parent's innate musicality. This can ultimately give them a way to engage with each other. As Levinge describes in an example from her work with a depressed mother and her child: "It would seem that by seeing her son play together with me in the music, she is brought to life herself" (Levinge 2011: 44). The musical gestures of the child, developed through his playing with the music therapist, release the mother's musical 'aliveness'. This enables her to engage with her son and eventually the therapist is able to step back and musically support the dyad.

## References

- Levinge, A. (2011). 'The First Time Ever I Saw Your Face...': Music Therapy for Depressed Mothers and Their Infants. In J. Edwards (Ed.), *Music Therapy and Parent-Infant Bonding* (pp. 42-57). Oxford: Oxford University Press.

## Reflection paper 3

### Why 'why'?

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Many presenters today respond to the 'Why?' questions by referring to theories and philosophical ideas, sometimes with a political agenda. When I ask myself the same 'Why?' questions, I do the same thing: I start to explain these questions with labels that are 'fashionable' in 2016; labels such as 'resource-oriented', 'empowerment', 'communicative musicality', etc. These concepts and their theories are, of course, valuable to music therapy. However, is this just a matter of language? Is not language a fleeting phenomenon? Do we not expect new labels and fresh theories to take over our reasoning for using music and being music therapists? Why is 'Why?' difficult for music therapists? (This question has occupied me for a long time, actually.)

The first question (*'Why music in music therapy?'*) seems to be somehow more basic than the other question; is not music basically something we *do* as human beings and does music not – whether it is music-making or music-listening – help us understand what it means to be a human being? "Music's role is not to stimulate feeling, but to express it", said Suzanne Langer (1952). To express oneself through music affords a form that children and young people (with or without challenges and/or disabilities) often find familiar and motivating. In today's child research (in the social sciences) the child is no longer seen as an object of knowledge acquisition but as an acting subject who has her own voice. The child, in fact, now has a right to speak up, and we are committed to listen to her before making decisions about her. Can music therapy provide a way to support the child to speak up? Can music therapy provide ways for us all to listen to the child's voice? How do we do this in practice and in musical terms?

When it comes to the other question (*'Why and*

*when is a music therapist needed?'*), this is a more complex matter. Is not music therapy idealistically a practice and profession of solidarity? Should we respond to this 'Why?' question with *'Because we want to make a difference'*, or *'Because we know that music can help making a difference'*? When does 'helping' turn into anti-oppressive actions? Is music therapy not a question of ethics and obligation too?

In Norway, the Child Welfare System builds on systematic and evidence-based research, and recent research in music therapy has offered some valuable contributions. We need, however, more; much more. For children and young people with attachment/communication and developmental problems, musical activities directed by a music therapist could create a positive value in their lives, so that they could bond meaningfully and build constructive, social relationships with other children and youths. This could be of importance for them in the long run and of vital ecological importance for society too. The opposite – and especially the extreme opposite – is dangerous and scary. Khan, the British reporter, says in her documentary film of young Jihad fighters, that their radicalisation is primarily explained by the pain the young people feel by meeting racism, exclusion, marginalisation, and isolation.<sup>9</sup>

The music therapy stories presented in this symposium show that taking part in music emerges as an existential value and a social potential where individuals can flourish (as Katrina McFerran said) through musical expression. Stensæth and Jenssen (2016) highlight dialogue as a key element in participation. For musical participation to become dialogic the 'I' must become competent within a 'we'-community, which is when the 'I' faces 'the Other' (Bakhtin 1981). Gro Trondalen, in her lecture paper (in Part 3), discusses this too. This requires a dialogical mind-set, a mutual acceptance and a willingness from both the child and the therapist so that they can explore and negotiate actions and meanings through their music. This musical responsiveness could be seen as a premise for any outcome in music therapy (Stensæth in press).

Does my meta-perspective here really respond

<sup>9</sup> See the documentary here:

<https://tv.nrk.no/program/KMTE30000614/jihad-hellige-krigere>

to the 'Why?' questions in this conference? Or is the prominent question of a much more practical nature: do music therapists communicate the need for music and music therapists in a way that society understands and believes enough for it to take action, creating more positions in music therapy practice and research?

## References

- Bakhtin, M. (1981). *The Dialogic Imagination*. Austin, TX: University of Texas Press.
- Langer, S. K. (1953). *Feeling and Form: A Theory of Art*. New York: Charles Scribner's Sons.
- Stensæth, K. (in press). *Responsiveness in Music Therapy Improvisation: A Perspective Inspired by Mikhail Bakhtin*. Dallas, TX: Barcelona Publishers.
- Stensæth, K., & Jenssen, D. (2016). "Deltagelse" – en diskusjon av begrepet. In K. Stensæth, V. Krüger & S. Fuglestad (Eds.), *I transitt – mellom til og fra: Om musikk og deltagelse i barnevern* (pp. 15-36). Oslo: Centre for Music and Health.