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Στο παρασκήνιο

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Καλώς ήλθατε σε αυτό το νέο τεύχος του *Approaches*. Παρόλο που δημοσιεύεται με μερική καθυστέρηση, ελπίζουμε αυτό το τεύχος να πυροδοτήσει τον διάλογο και να προσφέρει νέες πρακτικές, θεωρητικές και ερευνητικές προοπτικές. Μερικά άρθρα συμπεριλήφθηκαν στην Πρώτη Ματιά του *Approaches* πριν από ένα ή δύο χρόνια ωστόσο το περιεχόμενό τους παραμένει σχετικό με τις σύγχρονες εξελίξεις στο πεδίο της μουσικοθεραπείας.

Στο άρθρο της, η Saville εστιάζει στη μέτρηση αποτελεσμάτων με ιδιαίτερη αναφορά στο 'East Kent Outcomes System' (EKOS). Η εφαρμογή του EKOS, ως μέσου εντοπισμού και καταγραφής αποτελεσμάτων συμμετοχής στη μουσικοθεραπεία, επεξηγείται μέσα από μία μελέτη περίπτωσης με έναν ενήλικα με νοητική αναπηρία. Το έργο της Saville ανταποκρίνεται στο διευρυνόμενο ενδιαφέρον για τη μέτρηση αποτελεσμάτων στη μουσικοθεραπεία (Spiro, Tsiris & Cripps 2018a, 2018b). Παρομοίως, οι Πασιαλή, Schoolmeesters και Engen παρουσιάζουνε μια λεπτομερή ανάλυση κλιμάκων αξιολόγησης της ψυχικής ανθεκτικότητας (resilience). Σκιαγραφούν διάφορους τρόπους με τους οποίους οι μουσικοθεραπευτές μπορούν να προσεγγίσουν την αξιολόγηση της ανθεκτικότητας και να χρησιμοποιήσουν τα αποτελέσματα προς ενημέρωση της κλινικής τους πρακτικής.

Οι Silverman και Baker στρέφουν την προσοχή στην έννοια της ροής (flow). Εξερευνούν τα νοήματα και τη δυνατότητά της ως μηχανισμού αλλαγής ο οποίος μπορεί να εξηγήσει ερευνητικά αποτελέσματα στη μουσικοθεραπεία. Από την άλλη πλευρά, η Neudofer παρουσιάζει μια μεταθεωρητική προοπτική της μουσικοθεραπείας μέσα από το πρίσμα της ανθρωπολογικής θεωρίας του Baier για την πνευματικότητα. Μέσα από αφηγήσεις ασθενών από μια μελέτη έρευνας, αναζητά τους τρόπους με τους οποίους οι καρκινοπαθείς προσδιορίζουν τις μοναδικές του ιστορίες και βρίσκουν μια αίσθηση ταυτότητας και νοήματος.

Βασισμένο σε μια εθνογραφική μελέτη σε δύο σπίτια φροντίδας ηλικιωμένων, το τελευταίο άρθρο προσφέρει μια εμπειρική περιγραφή του ταγκό κατά τη μεσοπολεμική Ελλάδα. Η Κουφού εξερευνά τις εμπειρίες των ανθρώπων σχετικά με το τάνγκο από μια κοινωνικο-πολιτισμική προσέγγιση, συνθέτει διάφορα αποσπάσματα προφορικής ιστορίας, και παρουσιάζει τις πιθανές επιπτώσεις του ταγκό στην παρούσα αίσθηση ταυτότητας και ευεξίας των συμμετεχόντων.

Πέρα από αυτά τα πέντε άρθρα, σε αυτό το τεύχος θα βρείτε μια συνέντευξη της Barbara Wheeler, μιας εξέχουσας προσωπικότητας και συγγράφεα πολλών μουσικοθεραπευτικών εγχειριδίων. Ερωτώμενη από την Daphne Rickson, η Wheeler μιλά για την έρευνα στη μουσικοθεραπεία χρησιμοποιώντας ως πλατφόρμα τη δημοσίευση της τρίτης έκδοσης του βιβλίου *Music Therapy Research*. Μερικές από τις ιστορικές προοπτικές που προσφέρονται στη συνέντευξη της Wheeler συγκλίνουν με αυτές στην αναφορά της Suzanne Hanser. Μέσα από την εξιστόρηση της εγκαθίδρυσης και εξέλιξης της μουσικοθεραπείας στο Berklee College of Music στις ΗΠΑ τα τελευταία 20 χρόνια, η Hanser σκιαγραφεί ορισμένα ευρύτερα θέματα που αφορούν τη σύγχρονη εκπαίδευση των

μουσικοθεραπευτών (βλ. επίσης: Coombes & Etmektsoglou 2017). Αυτό το περιοδικό τεύχος περιέχει ακόμη εφτά βιβλιοκριτικές, εννέα αναποκρίσεις από συνέδρια, καθώς και ένα αφιέρωμα στην Mary Priestley η οποία απεβίωσε στις 11 Ιουνίου 2017.

Από το τελευταίο τεύχος του περιοδικού το 2017 μέχρι και σήμερα, η ομάδα του *Approaches* εργάζεται για τη βελτίωση της υποδομής του περιοδικού και των διαδικασιών αξιολόγησης και δημοσίευσης των κειμένων. Αυτή η εργασία η οποία λαμβάνει μέρος στο παρασκήνιο είναι ουσιώδης για την βιωσιμότητα του περιοδικού καθώς εισερχόμαστε σταδιακά στη δεύτερη δεκαετία της ζωής του. Μεταξύ άλλων εξελίξεων, εφαρμόζεται πλέον μια πενταετής περίοδος υπηρεσίας για όλα τα μέλη της Συμβουλευτικής Συντακτικής Επιτροπής. Ως εκ τούτου, μερικά μέλη με πολυετή προσφορά στο περιοδικό αποχώρησαν και μερικά νέα μέλη προστέθηκαν στην ομάδα. Με αυτήν την ευκαιρία θα θέλαμε να ευχαριστήσουμε θερμά τους Catherine Carr, Τέο Δημητριάδη, Ιωάννα Ετμεκτσόγλου, Παναγιώτη Καμπύλη, Παναγιώτη Κανελλόπουλο και Ευαγγελία Παπανικολάου για την προσφορά τους τα τελευταία χρόνια. Ταυτόχρονα, υποδεχόμαστε τους Bolette Daniels Beck, Kjetil Hjørnevik και Mike Silverman. Η εθελοντική εργασία όλων των μελών της ομάδας του *Approaches* έχει παίξει και εξακολουθεί να παίζει καθοριστικό ρόλο για την εξασφάλιση της ποιότητας των δημοσιεύσεων που εμφανίζονται στο περιοδικό. Με απώτερο σκοπό την πρόοδο της μουσικοθεραπευτικής γνώσης και πράξης, η συντακτική μας ομάδα έχει συνεργαστεί με περισσότερους από 400 συγγραφείς και 100 κριτές μέχρι σήμερα. Η πλήρης λίστα με τα ονόματά τους είναι διαθέσιμη εδώ: http://approaches.gr/el/editorial-board

Κλείνοντας, ευχαριστούμε θερμά τους χορηγούς του περιοδικού και ανακοινώνουμε με χαρά δύο νέους χορηγούς: το Κέντρο Μουσικής Ψυχοθεραπείας «ηχώ», και τον οργανισμό Music Therapy New Zealand. Η υποστήριξη όλων των χορηγών παρέχει τους απαραίτητους πόρους για τη συνέχιση του έργου μας και για τη διατήρηση του *Approaches* ως περιοδικού ανοικτής πρόσβασης.

ΒΙΒΛΙΟΓΡΑΦΙΑ

Coombes, E., & Etmektsoglou, I. (2017). Glimpses into the challenges and opportunities of a new training programme: The MA Music Therapy programme at the University of South Wales. *Approaches: An Interdisciplinary Journal of Music Therapy, 9*(1), 120-127.

Spiro, N., Tsiris, G., & Cripps, C. (2018a). A systematic review of outcome measures in music therapy. *Music Therapy Perspectives, 36*(1), 67-78.

Spiro, N., Tsiris, G., & Cripps, C. (2018b). “Sounds good, but… what is it?” An introduction to outcome measurement from a music therapy perspective. *Approaches: An Interdisciplinary Journal of Music Therapy*, First View (Advance online publication), 1-19.

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Τσίρης, Γ., & Πασιαλή, Β. (2018). Στο παρασκήνιο. *Approaches: Ένα Διεπιστημονικό Περιοδικό Μουσικοθεραπείας, 10*(1), 3-4.

Editorial

Behind the scenes

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Welcome to this new issue of *Approaches*. Although published with some delay, we hope that this issue will stimulate dialogue and offer new perspectives to practice, theory and research. Some articles were included in *Approaches'* First View section one or two years ago but their content remains relevant to contemporary developments in the music therapy field.

In her article, Saville focuses on outcome measurement with specific reference to the 'East Kent Outcomes System' (EKOS). The application of EKOS, as a means of identifying and tracking outcomes of participation in music therapy, is illustrated through a case example with an adult with intellectual disability. Saville's work adds to the expanding interest in outcome measurement in music therapy (Spiro, Tsiris & Cripps 2018a, 2018b). Similarly, Pasiali, Schoolmeesters and Engen present a detailed analysis of measures of resilience. They outline various ways music therapists may look into assessing resilience and use the results as a way to inform their clinical practice.

Silverman and Baker turn the spotlight on the notion of flow. They explore its meanings and its potential as a possible mechanism of change that can explain research outcomes in music therapy. On the other hand, Neudofer presents a metatheoretical perspective of music therapy through the lens of Baier's anthropological theory of spirituality. Through patient narratives emerging from an action research study, she explores how patients with cancer identify their unique stories and find a sense of identity and meaning.

Based on an ethnographic study in two homes for the elderly, the final article offers an experiential description of tango during the interwar period in Greece. Koufou explores people's experiences of tango from a socio-cultural point of view, weaves oral history snippets together, and presents the potential impact of tango on the current sense of identity and wellbeing of the participants.

In addition to these five articles, in this issue you will find an interview with Barbara Wheeler, a prominent figure and author of multiple music therapy textbooks. Interviewed by Daphne Rickson, Wheeler reflects on music therapy research, using the publication of the third edition of *Music Therapy Research* as a springboard. Some of the historical perspectives offered in Wheeler's interview resonate with those in Suzanne Hanser's report. Through the account of the establishment and development of music therapy at Berklee College of Music in the USA over the past 20 years, Hanser outlines some broader issues pertaining to the contemporary training of music therapists (see also: Coombes & Etmektsoglou 2017). This journal issue also includes seven book reviews, nine conference reports, as well as a tribute to Mary Priestley, who died on 11th June 2017.

Since the last journal issue in 2017, the team of *Approaches* has been busy improving the journal's infrastructure and streamlining its reviewing and publication procedures. This work that happens behind the scenes is essential for the sustainability of the journal as we are gradually entering the second decade of its life. Among other developments, a five-year service period has been introduced for all Advisory Editorial Board members. As such, some longstanding members stepped down and some new members joined the team. With this opportunity we would like to warmly

thank Catherine Carr, Theo Dimitriadis, Ioanna Etmektsoglou, Panagiotis Kabilis, Panagiotis Kanellopoulos and Evangelia Papanikolaou for their service over the past years. At the same time, we have welcomed Bolette Daniels Beck, Kjetil Hjørnevik and Mike Silverman. The voluntary work of all team members has played, and continues to play, a decisive role in ensuring the quality of the publications appearing in *Approaches*. With the ultimate goal of advancing music therapy knowledge and practice, our editorial team has collaborated with over 400 contributing authors and 100 reviewers to date. A full list of their names has been made available online: http://approaches.gr/editorial-board

In closing, we warmly thank the sponsors of *Approaches* and we are pleased to announce two new sponsors: 'echo' Music Psychotherapy Center, and Music Therapy New Zealand. The support of all sponsors provides the essential means to continue our work and maintain *Approaches* as an open-access journal.

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Spiro, N., Tsiris, G., & Cripps, C. (2018a). A systematic review of outcome measures in music therapy. *Music Therapy Perspectives, 36*(1), 67-78.

Spiro, N., Tsiris, G., & Cripps, C. (2018b). "Sounds good, but… what is it?" An introduction to outcome measurement from a music therapy perspective. *Approaches: An Interdisciplinary Journal of Music Therapy*, First View (Advance online publication), 1-19.

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Article

Applying the 'East Kent Outcomes System' (EKOS) in music therapy

Rhian Saville

ABSTRACT

This paper examines the current expectations for measuring clinical outcomes within the healthcare system in the UK, and introduces an application of the East Kent Outcomes System (EKOS) (Johnson & Elias 2010) as a means of measuring the clinical effectiveness of music therapy. The aim of the article is to describe how the system was implemented within Nottinghamshire Healthcare NHS Foundation Trust and to demonstrate its use within music therapy practice. The application of EKOS is illustrated through a case study with a client in the Intellectual Disability Service. Examples are given of how the data gathered can be used for reporting the effectiveness of music therapy, along with implications for the future use of the EKOS within the music therapy profession.

KEYWORDS

music therapy, outcomes, evaluation, clinical effectiveness, assessment and treatment, EKOS

Rhian Saville is Lead Clinical Specialist Music Therapist in the Intellectual Disability Service at Nottinghamshire Healthcare Foundation Trust. She trained at the Guildhall School of Music and Drama and subsequently gained her MA from Anglia Ruskin University. She has over 20 years' experience in working with children and adults with intellectual disability and has an interest in evaluating services and measuring therapeutic outcomes. Rhian has led the application of the East Kent Outcomes System (EKOS) for arts therapists across the Trust and runs bespoke training on the system for music therapists across the UK.

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INTRODUCTION

Music therapists are expected to provide effective treatment and care, reflect on their work, and demonstrate evidence-based practice. They are under pressure to achieve good results, meet contact targets, and prove that they are good value for money for managers and commissioners. They therefore need to be able to measure what they are achieving, or their outcomes, in their everyday work.

This paper aims to examine the current expectations for measuring clinical outcomes within the healthcare system in the UK, and to discuss the East Kent Outcomes System (EKOS) as a measurement system. The paper begins with a contextual outline of music therapy outcome measurement across the contemporary healthcare landscape. The development and implementation of the EKOS within the Intellectual Disability Service of Nottinghamshire Healthcare NHS Foundation Trust will be described. The potential for using data generated from the system to create reports for service managers or commissioners will be shown, and a case study will illustrate how the

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EKOS is used to set therapy aims and objectives and evaluate the work. Finally, the paper will conclude with some critical reflections of the EKOS and considerations about how it may be utilised within the music therapy profession.

CONTEXT

Following a review of the healthcare system in the UK, Lord Darzi (2008: 50) advised that "Every provider of NHS services should systematically measure, analyse and improve quality". He stated that clinicians should demonstrate the effect of their care and treatment by measuring clinical outcomes, and the information gathered should be used to continuously improve their services. The *Mental Health Outcomes Compendium* also recommended that clinical analysis should be undertaken through outcome measures, which they defined as "The positive changes, benefits, learning or other effects that result from the work that clinicians do" (National Institute for Mental Health in England 2008: 6). More recently NHS England (2014: 8) aims to improve the future quality of services "by measuring what matters, requiring comprehensive transparency of performance data and ensuring this data increasingly informs payment mechanisms and commissioning decisions".

Whilst these documents refer primarily to services within the NHS, it is clear that their recommendations could and should also be applied to all places in which music therapists work, such as schools, forensic units, hospices, social health and care settings, and in private practice. The regulatory body for music therapists in the UK, the Health and Care Professions Council (HCPC), states in their *Standards of Proficiency for Arts Therapists* that in order to maintain safe and efficient practice (and indeed registration) therapists must "be able to assure the quality of their practice" (HCPC 2013: 11). It recommends that clinical monitoring and evaluation should be achieved by gathering information through qualitative and quantitative data, and by using recognised outcome measures in conjunction with the service user.

In 2009, Nottinghamshire Healthcare NHS Foundation Trust's Associate Director for Allied Health Professions (AHPs), Catherine Pope, raised the need for more rigorous measurement and evaluation, and she was driven to find a suitable system that could measure our clinical outcomes. It needed to be accessible to all the therapists across the Trust, who comprised of arts therapists, speech and language therapists, occupational therapists and physiotherapists. The services within which the therapists worked were diverse and included Child and Adolescent Mental Health Services, Forensic, Intellectual Disability, Mental Health Services for Older People and Adult Mental Health, all of which had both inpatient and community pathways.

The music therapy teams within the Trust are situated within the Adult Intellectual Disability and Forensic Services. When we researched the literature, there was very little evidence available in terms of music therapy specific outcome measures, either generally or more specifically to our clinical areas. Wigram (2006: 93) wrote that "One of music therapy's fundamental problems is the lack of formalised and standardised assessment tools and outcomes indicators". He criticised the lack of reporting of any such tools within the literature, thus resulting in poor reliability or validity, so "it remains difficult for us to provide concrete evidence for either the relevance of music therapy interventions or their outcome effect over time" (Wigram 2006: 93). More recently, Miller (2014: 12) states that

> "There is a growing body of research, using a variety of measures, which increasingly provides evidence for the efficacy of the arts therapies […]. In routine practice the use of measures, and reporting of results, seems not to be so common".

Music therapists have begun to adapt pre-existing tools to create music therapy outcome measures such as Lawes (2012), and Lindeck, MacKeith and Burns (2011), but these have limitations in that they were developed for children and so were not appropriate to use with the adult population groups within the Trust. Similarly and more recently, some outcome measures have been devised specifically for music therapy. These include the Music in Dementia Assessment Scales (MiDAS) (McDermott, Orrell & Ridder 2015) and a questionnaire to measure Interest in Music (IiM) (Gold et al. 2013). However, as these are for music therapy in dementia and adult mental health respectively, they were not appropriate for clients with intellectual disability. We therefore needed to find a method of monitoring and evaluating our work that was relevant and meaningful for our services.

APPLYING THE EAST KENT OUTCOMES SYSTEM

The music therapists in the Intellectual Disabilities Service had some previous experience of trialling an outcome measure for people with an intellectual

disability, as we had been invited to be part of the UK CORE-LD pilot in 2008. This was an adapted version of the *'Clinical Outcomes in Routine Evaluation – Outcome Measure'* questionnaire which covers wellbeing, problems/symptoms, life functioning and risk to self and others (Brooks, Davies & Twigg 2013). It was used with people who had a mild to moderate intellectual disability who were not in crisis, and it was administered twice – once at the beginning and again at the end of therapy so that it could be seen if there was any change over this time. The form consisted of a series of 17 questions about how the person feels. Examples included asking if the person had felt lonely, sad, frightened or unhappy. They were also asked if they had felt like hurting others or themselves, or if they had difficulty making friends or sleeping. The scoring system was a simple three point scale in which the client ticked one of three boxes: 'Not at all', 'Sometimes', or 'A lot'.

The process proved to be a useful experience for us as a team, as it gave us some insight into the benefits and difficulties of how information could be collated about a person's wellbeing and their progress in therapy. However, whilst the tool aimed to be an accessible assessment of a person's feelings, we found that it was limited only to those clients who had capacity to understand the text, reflect on their feelings, and complete the scoring system. This therefore excluded those who had a severe or profound intellectual disability. The guidelines also excluded those people who might have been in crisis. The requirement was that all of the questions would be asked in each session and for some, this hindered the natural flow of therapy.

Following this all of the therapists in the Trust were invited to attend some training days on a few other outcome measures to ascertain their potential in our services. The first of these was the Therapy Outcome Measure (TOM). It was led by Professor Pam Enderby, a speech and language therapist based at the University of Sheffield. This tool enables professionals working in health, social care and education to describe the abilities and difficulties of a client in four domains which are described as impairment, activity, participation and wellbeing, and their changes are monitored over time (Enderby & John 2015). It comprises an 11-point rating scale, which is based on specific clinical conditions, and it scores a person's ability from 'profound' to 'normal'. Whilst it seemed a relatively easy tool to use, as arts therapists we felt that it was not sensitive or descriptive enough to capture the more subtle changes that might take place within our work.

In contrast was the East Kent Outcome System (EKOS) (Johnson & Elias 2010). This could be used across all the AHPs in different services of the Trust and it seemed well suited to a more descriptive method of analysis. It appeared to be a simple and meaningful system which aimed to reflect evidence-based practice and good therapy planning. We were attracted to its collaborative focus, which allowed the client and/or carer to be involved in setting and reviewing therapeutic aims. The EKOS had the potential to either be used for individual clients or group therapy, and by either a single professional or a multi-disciplinary team.

Local evidence was available as Murphy and Logan (2009) had conducted a study in Nottingham using the EKOS for their multi-professional team. Their aim was "to identify and test the feasibility of using a generic outcome measure for all members of the multi-professional team" (Murphy & Logan 2009: 482). The EKOS was chosen as the framework to achieve a single set of notes and outcome measure across four intermediate care teams. Methods included collecting clinical information from case notes over the period of a year. Data from each summary record was stored and analysed using an excel database. This included: the number and type of aims set per patient; the number of aims achieved; the time taken to achieve the aims; the health benefits that were associated with the aims; and any contributing factors that might have affected the aims. Conclusions were that the use of the EKOS appeared to be an easy and acceptable way for care teams to record aims relating to patients, and to measure how many are achieved. However, they identified the limitations as being: 1) EKOS is not a standardised measurement system, 2) each service set its own generic overall aims so outcome measures could not be compared across services, and 3) there is a scoring system that calculates an overall outcome for each aim, but there is no method for weighting aims.

IMPLEMENTING THE EAST KENT OUTCOMES SYSTEM

Following these training events, the music therapy team, along with other therapists in the Trust, decided to use the EKOS as a means of measuring clinical outcomes in their work. Further teaching with Maggie Johnson, Lead Speech and Language Therapist in Kent Community Health NHS Foundation Trust, took place in spring 2010 so that all staff had a good understanding of the tool, and

meetings were held for profession-specific groups to plan the way forward for each of their teams. The Trust arts therapists met bi-monthly to devise a list of common aims that would be suitable within our clinical work, and we trialled some case studies together. Follow-up sessions were then held in autumn 2010; these were useful in that we were encouraged to bring case studies to work through, along with any questions, difficulties or issues that had been identified. After this we felt more confident to roll out the tool across our services and so from spring 2011 it was piloted with each new referral. Initial drafts were sent to the trainer via email, in which she gave valuable feedback to further deepen our understanding. We set up an evidence-based resource on the shared drive of our computer system so that the completed forms that had been marked by the trainer were available to all as a guide.

Throughout this period, regular liaison took place with the other therapy teams within the Intellectual Disability Service. We were able to support each other by sharing examples of how we were using the system, and within the music therapy service we brought cases to our monthly team meetings for discussion. The EKOS audit tool (Johnson & Elias 2010) was used to monitor how the therapists were using their data so that good standards and consistency were maintained.

Our application of the EKOS was therefore developed and fully rolled out at the beginning of 2012. During the first year, 49 EKOS plans were completed within the music therapy team, with 92% achieving a good outcome (Johnson & Elias 2010).

DESCRIPTION OF THE EAST KENT OUTCOME SYSTEM

The outcome system is described as not being an outcome measure in itself; rather it “provides a framework for producing and evaluating individual treatment plans which draw on evidence-based clinical practice” (Johnson & Elias 2010: 6). It is a simple two-page form that is based on therapy goals, and it aims to be a summary of what is planned for and achieved during the course of the work. It is a collaborative process between the therapist, client and/or carer. If the client is able to, they can think jointly with the therapist about why they are attending therapy and what their aims might be. The form can then be completed together so the purpose of therapy is clear to all involved.

Once the referral is made and an assessment is completed, the therapist is ready to begin drafting his or her treatment plan. It consists of the following main sections:

Client needs group: This is a list that can be created uniquely by each professional group. It categorises the different types of client, for whom the therapist would expect similar aims, outcomes and level of service provision. The music therapy team based theirs on the most common reasons for referral (for example self-expression, anxiety, challenging behaviour, etc.) as it was felt that this information would be most relevant to the service and would provide meaningful data for managers and commissioners.

Health benefit: This is the broad category of overall anticipated health gain for the service user. The categories are set by EKOS and are shown in Table 1.

Health benefit	Definition
1. Reassurance provided	To give reassurance that no problem has been identified.
2. Problem resolved	To resolve a problem to an acceptable level.
3. Facilitated development	To achieve full potential by facilitating development or growth.
4. Restored function	To achieve full potential by restoring function as fully as possible after injury, disease, trauma, etc.
5. Function preserved	To preserve function or minimise deterioration.
6. Modified / adapted regime	To enhance the client’s quality of life by adopting alternative methods of functioning or making adjustments to live with and compensate for chronic conditions.
7. Harm avoided	To remove or minimise the risk of harm to the client or others.
8. Health promotion	To promote better health through anticipatory care and health education.
9. Supported	To support client with pain, grief, anger, guilt, etc.
10. Information provided	To provide information regarding a specific issue.

Table 1: Health benefits set by EKOS

Reason for intervention: This is a useful summary of why the client has been referred.

Therapy package and timescale: A self-explanatory section in which individual or group sessions are named along with the proposed

timescales for therapy.

Consideration of consent: It is important to demonstrate that issues of capacity and consent for therapeutic intervention have been considered and evidenced. If the client lacks capacity, a best interests decision should be made and recorded here.

Service user's views/comments on intervention: The method is designed to be a collaborative process with the client, so that if they are able, they are encouraged to reflect on and discuss why they are attending therapy and what they would like to achieve. These boxes therefore provide an opportunity if appropriate to capture their thoughts before and after the intervention.

Overall aims: The aims of the intervention are linked to the health benefit, and they identify the long-term purpose of the intervention. They are specific to each profession, so a list of aims applicable to arts therapists was devised as a result of many months of work between the various arts therapies teams across the trust. These were based on existing methods of goal setting that were already being used in the teams, which had been informed by models such as Bruscia (1987) and Baxter et al. (2007).

It is usual that every service that uses EKOS develops their own aims, treatment protocols, etc. so the following list therefore comprises the most common groups that our therapists were working to. These were relevant across both adult and child services, which included Intellectual Disabilities, Child and Adolescent Mental Health Services (CAMHS) and Forensic.

A – Assessment and treatment aims
B – Emotional issues
C – Relationships
D – Communication
E – Psychological development/personality
F – Behaviour
G – Other.

Each section (A-G) has between one and three specific aims within it; these explain the reasons for therapy and more than one can be identified at any time. Examples include: A2: To identify the key issues and aims for the client; B1: To enable the client to increase their ability to express emotions; E2: To foster self-esteem and self-confidence etc.

Baseline: When an aim has been selected, a description of the current baseline is given (for example, what is happening now?). This is a measurement or judgement noted before the intervention, against which change can be measured.

Objectives: The objectives are then set. These are directly linked to the aims and they describe exactly what the therapist is working towards achieving. For instance, this might be a specific skill, behaviour or situational change. The objective must be SMART (Specific, Measurable, Achievable, Realistic and Timely) so that it is possible to state clearly whether or not it has been achieved.

Treatment plan: This details the therapy approaches and techniques used towards meeting the objectives, thus demonstrating how the therapy is to be delivered.

Final evaluation: Evidence of how the objectives have or have not been achieved is detailed in the final section. From this the outcomes can be recorded. They are then added up and given as a percentage on a four-point scale as shown in Table 2, with 'good' outcomes ranging from 70-100% and 'poor' outcomes being less than 70% achieved.

When the recorded outcome is 'poor' (i.e. partially or not achieved), it is necessary to note the reason for this by choosing up to two possible contributory factors from a designated list as follows in Table 3.

Additional discharge information: This section provides an opportunity for any other relevant information related to the client's discharge to be documented. This could include further recommendations/signposting to other services and so on.

REPORTING AND FURTHER EVALUATION OF DATA

Once the therapist has evaluated the effectiveness of the intervention and recorded the outcome, the overall percentage of good outcomes can be a useful performance indicator for the service as a whole. Examining the reasons for poor outcomes is also beneficial for monitoring therapy trends across the team. For example, if they are therapist-orientated (such as setting aims that are overambitious or inappropriate) this might have implications for further training or support, whilst if the reasons are to do with a lack of support from staff, this can be positively addressed.

The Nottinghamshire Healthcare NHS Foundation Trust currently uses an electronic patient records and management system called 'Rio'. This is a web-based electronic care record system which was created as part of the National Programme for Information Technology in the NHS. Rio was designed for health and social care organisations that needed a single source of

information about patients or clients. In our Trust, all professionals involved with a patient can access their electronic records and add information to the system such as weekly progress notes or completed assessments.

The EKOS is formatted into the Rio system so that the completed data can be extracted and reported on. This is particularly advantageous when teams are required to compile reports and communicate their outcomes to managers and commissioners. Examples of data that can be used are: what are the most commonly used health benefits or aims, what are the numbers within each client needs group, percentage of good outcomes, reasons for poor outcomes, number of EKOS forms completed by each team member, and so on.

For example, in 2014-15, 45 EKOS plans were completed in the music therapy team. The data showed that overall 96% of these had good outcomes (i.e. more than 70% of their objectives were achieved). Figure 1 shows the breakdown of these by *health benefit*, so that those with the highest outcomes were facilitated development, function restored, harm avoided, and supported.

Good outcomes			Poor outcomes	
Fully achieved	***Mostly achieved***		***Partially achieved***	***Not achieved***
100% objectives met	70 -100% objectives met		<70% objectives met	0% objectives met
All objectives are met.	3 out of 4 4 out of 5 5 out of 6 6 out of 7	6 out of 8 7 out of 9 7 out of 10	1 out of 2 2 out of 3	No objectives are met.

Table 2: Calculating the overall outcome

Possible contributory factors influencing outcome: Record if outcome less than 70% (please tick up to 2)		
Poor attendance	Overambitious aims / objectives	Transferred to another service/team
Therapist absence	Deteriorating health	Lack of agreed support
Slower progress than expected	Delay in planned delivery of care	Lack of involvement (client)
Unable to complete the course	Inappropriate aims / objective / intervention	Unforeseen life event
Deceased	Unmet need – funding of equipment	Unmet need – service gap

Table 3: Possible contributory factors influencing poor outcome

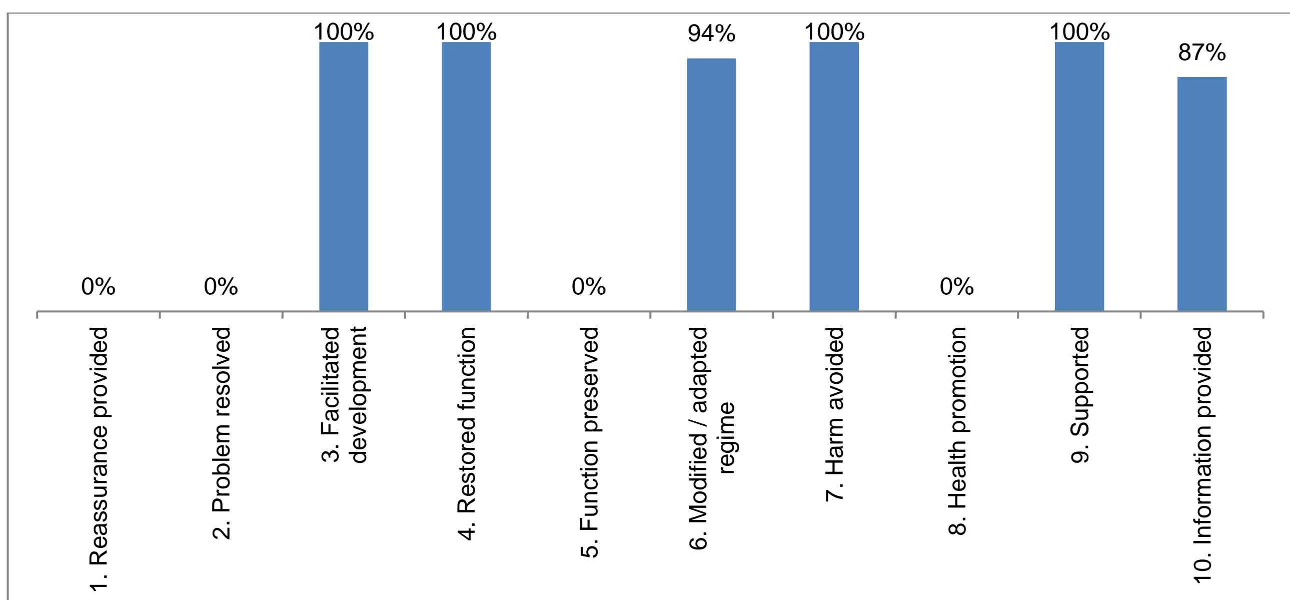


Figure 1: Percentage of good outcomes by health benefit

CASE EXAMPLE

This brief case example aims to demonstrate how the EKOS can be used in music therapy practice. It is based on a case from the Intellectual Disability Service in Nottinghamshire Healthcare NHS Foundation Trust.

The Intellectual Disability service

The service provides specialist health care for adults with intellectual disabilities and complex needs such as additional physical health problems, additional mental health problems, or serious risk issues. Assessment and treatment is delivered within a stepped model. Routine assessment and treatment is delivered within nine multi-disciplinary and multi-agency Community Learning Disability Teams across Nottinghamshire. More intensive assessment and treatment, where there has been an increase in risk or deterioration in mental health, is delivered by two multi-disciplinary Intensive Community Assessment and Treatment Teams (ICATTs). The most intensive assessment and treatment for people who have an intellectual disability and associated challenging behaviour and mental health issues is delivered in the inpatient Assessment and Treatment Unit (ATU). Music therapy is currently available within the ICATTs and the ATU, with referrals being made by colleagues within these teams.

Mark

Mark, whose name has been changed to protect his identity, was a 30-year old man with autistic spectrum disorder who was living in a community home for people with intellectual disabilities. He was admitted to the ATU due to an increase in anxiety and possibly depression. Mark was referred to music therapy to help him express and explore his emotions, decrease his anxiety and improve his general wellbeing.

Assessment

Mark attended four assessment sessions which were recorded and analysed through clinical notes and video recording. He was able to stay for the whole 30 minutes each time, but he seemed quite tense, grimacing frequently, rolling his head from side to side and talking repetitively about topics such as birthdays and other clients. As he became familiar with the therapist and the sessions, however, he appeared to relax. Video recordings showed that he smiled more naturally, gave increased eye contact and focused more on the music rather than the repetitive speech. Mark was also noted to be compliant each week, as he would wait for the therapist to choose an instrument and begin playing it. However, when given a gentle verbal prompt, Mark was able to make choices for himself and lead the improvisations. The methods used in the assessment encompassed both relational and music-centred techniques (Wigram et al. 2002) to assess the development of a therapeutic relationship alongside the potential for musical interaction.

The music therapy department's assessment tool (Saville 2000) was used to record the findings from these initial sessions. In this tool, musical, interpersonal, sensory and physical observations based on Bruscia's model of Improvisation Assessment Profiles (Bruscia 1987) were documented and these were written up in an assessment report.

Treatment

The findings from the assessment formed the basis for the treatment phase of therapy, which consisted of ten further sessions over a three-month period, covering his discharge from the ATU through his transition back to his community home. Information from the assessment gave the baseline for the EKOS treatment plan which could now be implemented. This is illustrated in Figure 2 and the process was as follows:

a. The 'client needs group' was identified as 'anxiety' due to Mark's primary presentation.

b. The 'health benefit' was 'problem resolved' as it was felt that once he moved through the transition back to his home, his anxiety would decrease.

c. The timescale was decided as three months which would correspond with Mark's pending discharge from the ATU through the transition back to his community home.

d. Two main aims were identified: i) To enable Mark to manage difficult feelings during transition from ATU back to his community home, and ii) To foster self-esteem and self-confidence.

e. The baselines were matched against the aims, detailing how Mark was presenting at the beginning of the treatment episode.

f. The objectives were set by thinking about how musical and relational techniques could be used to achieve the aims: i) Mark to sustain a relaxed

dialogue about his transition to community during each session, ii) Mark to lead 50% of the improvisations during each session, iii) Mark to choose instruments independently in three successive sessions.

g. The aims and objectives for the therapy were considered within an integrative framework, so that early mother infant theories relating to affect attunement (Stern 1985), holding and play (Winnicott 1971), and containment (Bion 1962) informed the social and musical activities and interactions (Saville 2007). Due to Mark's anxiety and autistic presentation the therapist aimed to focus on containing his emotional state, encouraging relaxation and developing more autonomy and reciprocity. These techniques were detailed in the treatment plan, thus demonstrating the small steps that were to be implemented each week throughout the intervention.

Outcomes

At the end of therapy the outcomes were as follows. They were evidenced through case notes and video analysis and documented on the EKOS form with a 'Yes' and some accompanying text:

1. Mark engaged positively, and he continued to be interested in the instruments and our musical relationship.
2. Mark seemed to cope well with the discharge back to his new home, and he told the therapist all about it in the following sessions. He was noticeably happy and relaxed, playing easily and coping well with the change in routine of coming to the sessions.
3. Mark's attention and concentration was much improved when he was encouraged to play in structured ways – for instance "Follow my beat – 1, 2, 3". Otherwise when not so engaged he would talk repetitively to himself.
4. Mark's confidence increased so that he was able to choose instruments independently and take the lead in over half of the improvisations. He showed his pleasure after these by smiling.

Mark also coped well with the ending of therapy – he acknowledged this appropriately in the final sessions and he left with a sense of achievement and confidence.

DISCUSSION

This paper has examined the use of an outcome measurement system within a music therapy team for adults who have an intellectual disability. The expectation to monitor, evaluate and improve the quality of clinical services within the contemporary climate implies that robust methods of measuring outcomes should be routinely embedded into everyday practice, and the EKOS is a system that can enable clinicians to achieve this.

It was a challenge to find a form of measurement that suited our needs within Nottinghamshire Healthcare NHS Foundation Trust due to the limited resources and literature available regarding outcome measures. However, our experience of participating in the UK CORE-LD pilot along with training on TOMS and EKOS informed the therapy teams of best current practice and helped us decide to apply the EKOS within our services.

The system has several limitations in that firstly it requires in-depth training to fully understand its principles and methods. To ensure reliability and consistency within and across teams it is recommended that therapists should maintain and monitor their standards of its use through audit, supervision and peer discussion (Johnson & Elias 2010).

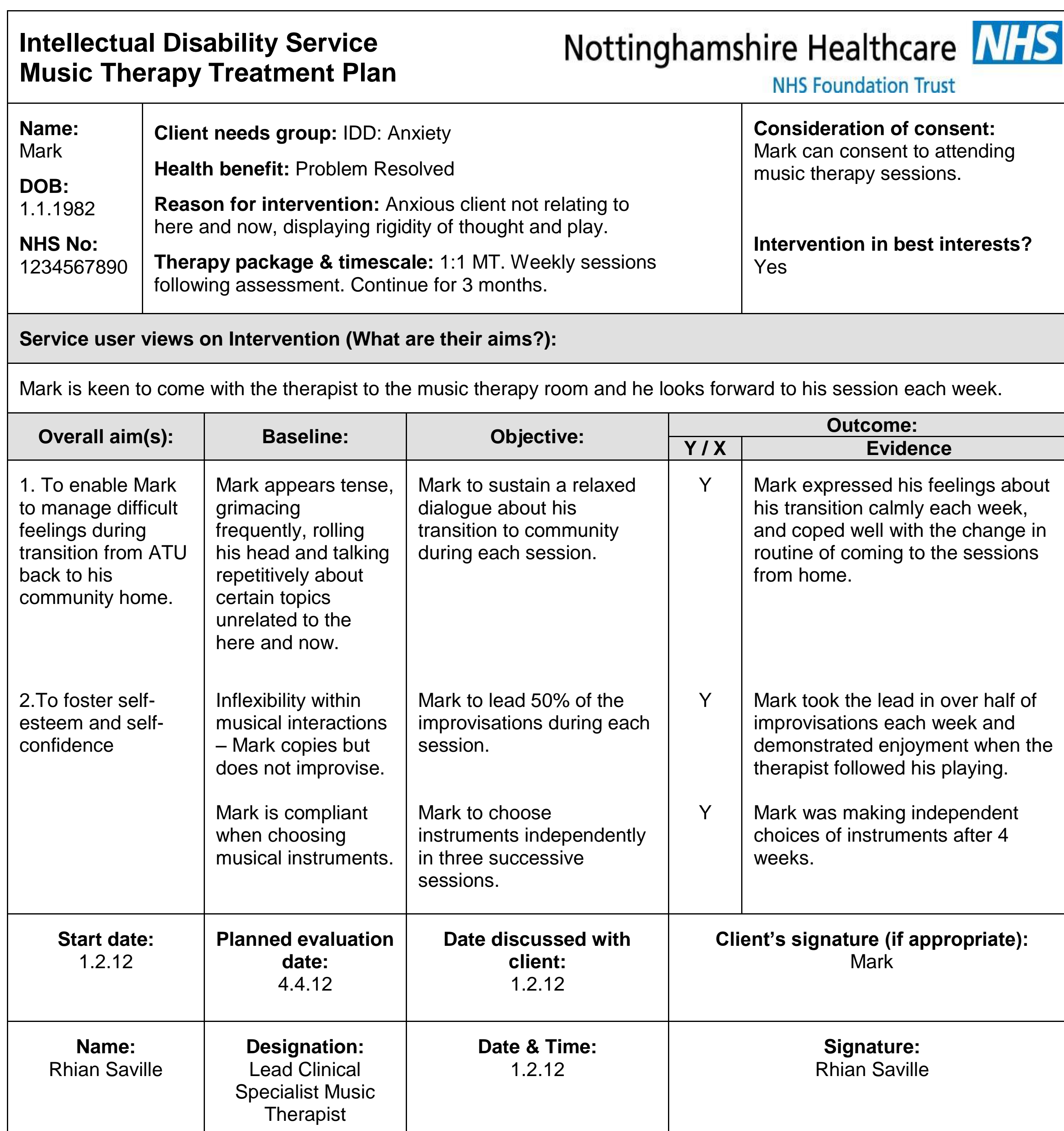
Secondly, whilst the system is not an outcome measure in itself, it provides a framework in which evidence from clinical practice can be documented. Rather than being a standardised system, it is more of a method for evidencing aims and objectives within therapeutic treatment plans.

Thirdly, the system has the potential to be a useful collaborative experience between client, carer and therapist, thus allowing for an early discussion of the expectations of therapy as well as giving an opportunity to reflect on the outcomes. However, this is naturally dependent on the capacity of the client to understand the purpose of the therapy and/or the written text. In our services, which include mental health services for older people and child and adolescent mental health services as well as intellectual disability, we provide an accessible version of the tool for clients in which the aims of therapy are detailed in a format that is much easier to understand.

In terms of the benefits of the EKOS, it is a fairly simple process which provides a clear structure for planning and evaluating therapeutic interventions. It

is based on existing good clinical practice and it enables the therapist to critically reflect on and develop their work. The flexibility of the EKOS allows each professional group to apply it within their individual services, whilst also providing a consistent, systematic method of analysis that enables comparison across clinical teams.

It is beneficial that data can be extracted from Rio reports so that information is available to analyse at all levels, from therapists through to managers and commissioners. The individual therapist, for example, might see trends emerging regarding favoured health benefits or reasons for poor outcomes, which might be useful to explore in supervision to check for consistency or good practice. Team managers might wish to produce annual service reports with data such as how many treatment plans were completed and what percentage of these had good outcomes. This information can be displayed through charts and graphs, which are a quick and concise way of communicating the value of the service alongside accompanying text or case studies. This is vital for commissioners who appreciate succinct evidence of an intervention they are purchasing.



Intellectual Disability Service
Music Therapy Treatment Plan

Nottinghamshire Healthcare NHS
NHS Foundation Trust

Name: Mark **DOB:** 1.1.1982 **NHS No:** 1234567890	**Client needs group:** IDD: Anxiety **Health benefit:** Problem Resolved **Reason for intervention:** Anxious client not relating to here and now, displaying rigidity of thought and play. **Therapy package & timescale:** 1:1 MT. Weekly sessions following assessment. Continue for 3 months.	**Consideration of consent:** Mark can consent to attending music therapy sessions. **Intervention in best interests?** Yes

Service user views on Intervention (What are their aims?):

Mark is keen to come with the therapist to the music therapy room and he looks forward to his session each week.

Overall aim(s):	Baseline:	Objective:	Outcome: Y / X	Outcome: Evidence
1. To enable Mark to manage difficult feelings during transition from ATU back to his community home.	Mark appears tense, grimacing frequently, rolling his head and talking repetitively about certain topics unrelated to the here and now.	Mark to sustain a relaxed dialogue about his transition to community during each session.	Y	Mark expressed his feelings about his transition calmly each week, and coped well with the change in routine of coming to the sessions from home.
2.To foster self-esteem and self-confidence	Inflexibility within musical interactions – Mark copies but does not improvise.	Mark to lead 50% of the improvisations during each session.	Y	Mark took the lead in over half of improvisations each week and demonstrated enjoyment when the therapist followed his playing.
	Mark is compliant when choosing musical instruments.	Mark to choose instruments independently in three successive sessions.	Y	Mark was making independent choices of instruments after 4 weeks.

Start date: 1.2.12	**Planned evaluation date:** 4.4.12	**Date discussed with client:** 1.2.12	**Client's signature (if appropriate):** Mark
Name: Rhian Saville	**Designation:** Lead Clinical Specialist Music Therapist	**Date & Time:** 1.2.12	**Signature:** Rhian Saville

Treatment plan (small step programme of intervention):
1. Provide weekly 1:1 MT sessions on Wednesdays at 2pm in MT room. 2. Provide similar structure to sessions each week. 3. Encourage Mark to choose instruments independently. 4. Encourage Mark to join in simple turn-taking and counted musical activities. 5. Help Mark to relax and engage in reciprocal musical and verbal dialogues. 6. Encourage Mark to talk about his transition.

Evaluated on:	**Date evaluated with client:**	**Client's signature (if appropriate):**
4.4.12	4.4.12	Mark

Overall outcome:	Fully (100%)	~~Mostly (>70%)~~	~~Partially (<70%)~~	~~Not (0%)~~

Possible contributory factors influencing outcome: Record if outcome less than 70% (please tick up to 2)		
Poor Attendance	Overambitious aims/objectives	Transferred to another service/team
Therapist Absence	Deteriorating Health	Lack of agreed support
Slower progress than expected	Delay in planned delivery of care	Lack of involvement (client)
Unable to complete the course	Inappropriate aims/objective/intervention	Unforeseen life event
Deceased	Unmet need – funding of equipment	Unmet need – service gap

Service user's comments on intervention
Mark said he felt calmer and happier after coming to music therapy.

Additional discharge information if required:
Recommendations made to home staff regarding building and sustaining positive relationships and reducing anxiety.

Name:	**Designation:**	**Date & Time:**	**Signature:**
Rhian Saville	Lead Clinical Specialist Music Therapist	4.4.12	Rhian Saville

Figure 2: Example of a completed EKOS Plan *[Form adapted from East Kent Outcome System (EKOS) (Johnson & Elias 2010)]*

Further applications

The EKOS is a simple and attractive system in which information about therapeutic aims, objectives and clinical outcomes can be captured and analysed. There are possibilities for it to be used in many other clinical or educational settings where therapists are interested in demonstrating evidenced-based practice. This can be done by either using the original EKOS templates (Johnson & Elias 2010), or by applying the tool and referencing EKOS (Johnson & Elias 2010) as the source. In either case, training would be necessary to ensure consistency of use and to maintain reliability.

The EKOS has been used successfully by all therapists across Mental Health, Intellectual Disability and Forensic services in Nottinghamshire Healthcare NHS Foundation Trust since 2010.There is a need for more methods of outcome measurement within the music therapy profession and so it is hoped that this system has the potential to be used with a wide variety of client groups in the future.

Conflict of interest

There are no conflicts of interest to note.

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Article

Mapping resilience: Analyses of measures and suggested uses in music therapy

Varvara Pasiali, Laree Schoolmeesters & Rebecca Engen

ABSTRACT

Resilience – which is a process and capacity for adaptation when experiencing adverse life circumstances or cumulative stress – seems to be a particularly relevant for music therapists. However, there are challenges when assessing resilience. We screened sources (N=307) and identified seven scales that provide a quantitative measure of the degree of resilience: Connor-Davidson Resilience Scale (CD-RISC), Child and Youth Resilience Measure (CYRM), Devereux Early Childhood Assessment (DECA), Dispositional Resilience Scale (DRS), Resilience Scale (RS), Resilience Scale for Adults (RSA), Resilience Scale for Adolescents (READ). We reviewed each scale, identified salient psychometric properties, and drew conclusions about practical uses in music therapy (screening, profiling for intervention, and measuring effects of treatment). Music therapists strive to promote clients' wellbeing and resilience measurement instruments may provide a way of screening, profiling for intervention, or establishing specific research protocols that target strength-based competencies. These measures, however, may only provide a snapshot of the total variables that may affect responses to treatment since adaptation is only relevant within the broad community systems in which each individual belongs.

KEYWORDS

resilience measures, assessment, screening, psychometric review

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Resilience refers to the process and capacity for adaptation when experiencing adverse life circumstances or cumulative stress. It may therefore be a useful concept in music therapy. Even though there are several instruments appropriate for music therapy, the task of measuring resilience is challenging. There are many definitions, it is a complex construct, and seemingly related characteristics (such as personality traits, measures of stress/anxiety) may not be helpful in predicting healthy resilient adjustment. We, the authors of this paper, two music therapists and a registered nurse, conceptualised this paper as an attempt to identify,

review and evaluate measures and assessment scales of resilience. Moreover, we aimed to suggest specific situations in which music therapists may use those measures in their clinical practice. Our target audience includes music therapists, researchers, clinicians, or both, who adopt a strength-based philosophy of clinical practice. A strengths-based practice involves shifting from an approach that emphasises symptoms and pathology, to one that focuses on positive experiences while developing coping skills and competencies (c.f. Rolvsjord 2015).

An inherent problem in conceptualising resilience is the plethora of definitions that exist in the literature. In general, resilience is the ability to adjust and grow in the face of adversity. As Luthar, Cicchetti and Becker (2000) point out, such conceptualisation generates questions as to what defines adjustment, the specific processes by which a resilient person adjusts; what constitutes adversity; or how timing, duration and sociocultural elements may support or hinder adaptation. Thus, resilience is a complex construct that represents both the process and capacity for successful adaptation in the face of adverse or challenging life circumstances (Masten, Best & Garmezy 1990).

This multidimensional nature of resilience poses further challenges in conceptualisation. First, people respond differently to comparable experiences at various times during their life trajectory. Resilience is a life-span process, not simply something that occurs in childhood (Rutter 2006). Moreover, some individuals may be resilient in one domain, but not in another. Individuals may be resilient across similar domains (e.g. academic achievement, studying habits), but not be resilient across distinct domains (e.g. academic achievement vs. social competence) (Luthar et al. 2000). Therefore positive adaptation is not uniform across all areas of functioning. As a result, broad phenomena may be studied under the umbrella of resilience. In developmental literature Masten (2007) identified three categories studied in resilience research: (a) following a typical developmental trajectory despite cumulative risks, (b) showing stress-resistance or coping during adverse situations, and (c) self-regulating and recovering after adversity or deprivation.

Resilience is not a personality trait or a coping mechanism. Certain personality traits or dispositional attributes, such as ego-resilience or hardiness, contribute to resilience and may serve as assets or protective factors. Luthar et al. (2000) point out that some confusion may arise from using the term resilience and resiliency interchangeably. Resiliency refers to a personal attribute whereas resilience connotes presence of a threat to adaptation and evidence of healthy adjustment in at least one domain of functioning. Characteristics of a person alone do not account for adaptive developmental outcomes. Adaptation emerges as a result of how an individual interacts with his or her environment and develops competence in age-appropriate and sociocultural defined tasks (Roisman et al. 2004).

The role of implementing personality testing in determining the validity of instruments measuring resilience is to identify how particular traits may co-vary with the resilience construct. Whereas correlating a resilience instrument with measures of personality contributes to construct validity, Friborg et al. (2005) point out that high redundancy is problematic. The more a particular factor of an instrument correlates with a personality trait, the less it contributes uniquely in measuring resilience. For example, optimism, a disposition measured in resilience instruments, was not correlated with other resilience variables in a sample of women with a family history of breast cancer (Bowen, Morasca & Meischke 2003). Another limitation of using personality inventories to validate resilience is that in adults, personality traits are not malleable to change.

Using measures of stress and anxiety also has inherent limitations in determining the validity of instruments measuring resilience. Some individuals may be more vulnerable to stress than others. Perception of stress, however, remains contextual. Environmental conditions and previous experience will determine which stressors are more or less challenging for particular individuals. Using measures of symptomatology or measures assessing healthy outcomes also has pitfalls. Knowing how a person deals with traumatic or negative life experiences may reveal more about the stressor itself rather than the adaptive capacity of the individual (Roisman 2005). Moreover, absence of symptoms is one way of coping with stressful situations. However, Roisman (2005) states that recovery may also be a form of resilience; individuals may experience a period of maladaptive coping prior to successful adaptation. Lastly, correlating scores obtained using instruments of resilience with scores obtained using instruments of social domain functioning is pivotal as healthy interpersonal relationships contribute to adaptation. Even though Wallace, Bisconti and Bergeman (2001) found that hardiness (which is relevant to resilient coping) mediated the relationships between social support and healthy

outcomes in a sample of older adults, they recommend considering both internal personality characteristics and external supports as relevant to wellbeing.

Given the above information, the task of creating a measurement instrument that captures the process of, capacity for, or outcome of successful adaptation may seem 'mission-impossible.' As cumulative risks increase, resources also decrease, making resilience harder to attain (Sameroff & Rosenblum 2006). Thus, if individuals who experience multiple risks score high on a resilience instrument, then that instrument is more likely to identify resilient individuals. An important realisation is that creating and using a measurement instrument will only measure some aspect of what contributes to resilience. Administering a resilience instrument (or measurement scale) is not a developmental analysis and cannot predict with absolute confidence an individual's trajectory. Findings in research literature indicate that resilient adaptation is fluid and can occur at any point during a person's developmental trajectory as a result of life experiences or in the context of relationships with others (Rutter 2006).

Regardless, resilience measurements are needed for various purposes. For example, measurement instruments can identify individual capacity for resilience, predicting difficulties in adaptation. Thus, mental health workers or health professionals may use such instruments in client assessment prior to therapy for gauging strengths and needs or for predicting ability to cope with forthcoming difficulties, tailoring interventions accordingly (Ahern et al. 2006; Connor & Davidson 2003; Friborg, Hjemdal et al. 2003). Moreover, psychometric study outcomes may aid researchers in identifying risk, promotive, protective and vulnerability factors affecting resilience.[1] In this paper we identified sources by conducting a formal overview of related literature.

METHOD

Identification of sources

A formal review of the music therapy, nursing and allied health primary research online databases using separate keyword searches ("resilience scale", "resilience measurement", "resilience psychometric study" and "resilience instrument") yielded 307 records. Each search was refined and limited to peer-reviewed sources. The primary database search included EBSCOHost, PsychINFO, CINAHL, ERIC and Ovid. We removed duplicates, book reviews, articles published in a language other than English, studies without a psychometric focus, studies in which the researchers did not measure resilience as the ability to adapt from adversity and studies in which researchers used storytelling or projective exercises (because they did not provide a quantitative objective measure of resilience). A total of 61 studies remained for additional screening. Subsequently, a secondary database search using names of resilience instruments or names of specific authors was conducted. The secondary search yielded an additional 66 records. To find additional sources we reviewed reference lists of book chapters and peer-reviewed articles about resilience measurement. Identification of sources concluded in April 2015.

Inclusion criteria

We screened 127 manuscripts and identified that researchers developed and used a total of 50 resilience measurement instruments. We selected and reviewed in detail only those measurements with at least four psychometric validation studies beyond the original research report, along with a minimum of four additional reported uses in the literature. The above criteria provided a subjective method of ensuring we were reviewing measures with reputable uses of social research. Table 1 includes the names of all the measures that met the inclusion criteria, a description of the theoretical

[1] Risk factors are variables that contribute to negative outcomes, whereas promotive factors are variables that contribute to positive outcomes regardless if an individual belongs to a high risk or a low risk group (e.g. parental school involvement). In essence, promotive factors have an overarching compensatory effect contributing to adaptation across various levels of risk. It is important to note that some factors may have a reactive effect; being effective under low levels but ineffective under high levels of risk fosters competence. Protective factors contribute to positive outcomes particularly in an individual belonging to a high-risk group. Protective factors may have an enhancing effect, facilitating adaptation as risk increases. Vulnerability factors contribute to negative outcomes only for low-risk groups. A vulnerability factor reduces positive outcomes in high-risk groups, but not in low-risk groups. When considering measurement instruments, it is critical to understand the above definitions. It also is important to recognise that what may constitute a protective factor in one domain may be a risk factor in another (Gutman, Sameroff & Cole 2003; Luthar 1993).

construct and the reference to the original validation study. Table 2 includes the names of all the measures that did not meet the inclusion criteria as well as the reference to the original validation study. Both tables are included in an appendix at the end of this paper.

Analysis approach

We retrieved information pertinent to discussing each measurement instrument by reading the main text of identified sources. For each measurement we discussed its development and relevant psychometric properties (scoring, administration, factor analysis, reliability and validity). When appropriate we differentiated our own opinions and interpretations from those of the original authors of each measure or from subsequent users. We also included a discussion of possible uses of each measure in music therapy research or clinical work.

RESULTS

We focused the discussion on the development of construct validity, as well as any other salient psychometric characteristics of each measure. In addition, we explored uses of those instruments in music therapy for screening, profiling for intervention and monitoring or measuring change. Seven measurement instruments met the inclusion criteria:

- Connor-Davidson Resilience Scale (CD-RISC)
- Child and Youth Resilience Measure (CYRM)
- Devereux Early Childhood Assessment (DECA)
- Dispositional Resilience Scale (DRS)
- Resilience Scale (RS)
- Resilience Scale for Adults (RSA)
- Resilience Scale for Adolescents (READ)

The first author of this paper has used the DECA and the CD-RISC in research and clinical work.

Connor-Davidson Resilience Scale (CD-RISC)

Overview

Connor and Davidson (2003) developed CD-RISC for screening typical functioning adults or adults with mental health problems as well as a method for evaluating treatment effectiveness. Inspired when reading about Sir Edward Shackleton's heroic expedition in the Antarctic in 1912 (Alexander 1998), they brainstormed on what type of personal characteristics would have contributed to resilience. Spirituality was one theoretical construct for this scale. They also derived theoretical information from a variety of other sources (Kobasa 1979; Lyons 1991; Rutter 1985) and included characteristics such as hardiness, seeking help, having secure attachments, patience, viewing change as a challenge and persevering to attain goals.

The CD-RISC scale has 25 items using a five-point Likert scale. It is a self-reported measurement that participants complete based on how they felt over the past month. The scoring is a summation of all the items. Scores range from 0-100 with higher scores equalling higher resilience (Connor & Davidson 2003). Standardisation scores do not exist in the literature and mean scores have varied among different populations. For example, reported means of different samples were US general population =80.7; primary care patients =71.8; psychiatric outpatients =68.0; generalised anxiety =62.4; two post-traumatic stress disorder (PTSD) samples =47.8 and 52.8 (Connor & Davidson 2003) and older-women =75.7 (Lamond et al. 2008). The scale has been translated into multiple languages such as Italian (Di Fabio & Palazzeschi 2012), Korean (Jeong et al. 2015; Jung et al. 2012), Turkish (Karaırmak 2010), Chinese (Wang et al. 2010) and Spanish (Notario-Pacheco et al. 2014). The reported test-retest correlation coefficient was 0.87 (Connor & Davidson 2003). Reliability properties have remained consistent and similar across different groups (Gillespie, Chaboyer & Wallis 2009; Yu & Zhang 2007a, 2007b). Cronbach's coefficients reported include 0.89 for Chinese adolescents (Yu et al. 2011) and 0.88 for Spanish patients with fibromyalgia who also demonstrated test-retest reliability of r=0.89 for a six-week interval (Notario-Pacheco et al. 2014).

Even though an exploratory factor analysis in the initial psychometric study indicated five possible factors (Connor & Davidson 2003), confirmatory factor analysis with different populations showed variations in the factor structure, indicating possible cultural differences and dissimilarities among different ethnic groups (Campbell-Sills & Stein 2007; Gillespie et al. 2009; Hartley 2008; Jorgensen & Seedat 2008; Khoshouei 2009). Due to the factor model instability, researchers recommend not scoring the subscales separately as originally reported by Connor and Davidson (2003) and score the CD-RISC as unidimensional (Burns & Anstey 2010). A shorter 10-item version of

the CD-RISC exists in the literature (Campbell-Sills & Stein 2007; Davidson et al. 2008; Gucciardi et al. 2011). Furthermore, researchers explored using a simple two-item scale as a method for evaluating pharmacological treatment of PTSD, depression and generalised anxiety disorder (Vaishnavi, Connor & Davidson 2007).

In order to verify the degree to which the CD-RISC evaluated resilience, Connor and Davidson (2003) correlated the instrument with measures of hardiness, perceived stress and stress vulnerability, as well as measures of disability and social support. A positive correlation between CD-RISC scores and the hardiness measure indicated that certain personality attributes contribute to resilience. A significant negative correlation with the stress scale indicated that people who are resilient have less perceived stress and thus are less vulnerable. In psychiatric patients, higher CD-RISC scores were related to lower scores of disability. Lastly, higher levels of social support also meant higher levels of resilience. Connor and Davidson (2003) correlated the CD-RISC with an unrelated measure (a sexual experience scale) and found no significant correlations, indicating divergent/ discriminant construct validity.

Additional researchers have assessed construct validity of the CD-RISC by comparing it against other measures. For example, Campbell-Sills, Cohan and Stein (2006) identified the relationship between coping styles, personality measures, psychiatric symptoms and resilience resulting in a positive correlation between CD-RISC scores and (a) extroversion (ability to thrive in social contexts) and (b) conscientiousness (planning and working systematically) personality characteristics. A negative correlation with neuroticism (lack of emotional stability) was found. Moreover, a high score on CD-RISC moderated the relationship between childhood trauma and adult psychological symptoms. Noteworthy, Campbell-Sills et al. (2006) found ethnicity effects; correlation between resilience and conscientiousness was significantly higher for members of ethnic minority groups when compared with scores of other participants. Similarly, other researchers found positive correlations of high CD-RISC scores with self-esteem and life-satisfaction (Yu & Zhang 2007a, 2007b), less athlete burnout (Gucciardi et al. 2011) and higher coping skills (Sexton, Byrd & von Kluge 2010). Finally, researchers using a sample of older women found a negative association between current psychiatric disorder and high resilience compared to low resilience level (Scali et al. 2012).

Recommendations for uses in music therapy

We recommend that researchers using the CD-RISC should currently consider it as a unidimensional measure, examining personal attributes, including faith and optimism. It is a self-report of personal qualities relevant to resilience. The first author has previously used the CD-RISC with non-clinical populations and found it easy to administer and score. The findings in studies we reviewed indicate that reliability has remained consistently high and with solid construct validity. We would like to caution researchers that CD-RISC scores may indicate specific characteristics of individuals that lead to resilience and may not provide information about the resilience process, which can be highly context-dependent. Thus, it may not capture changes resulting from participation in music therapy treatment.

The CD-RISC is not suitable for profiling for intervention. Clinicians may use CD-RISC as a quick screening scale of personal attributes that may buffer an individual during adverse life events. Such screening may allow triaging of individuals who may need additional support and focusing on bolstering personal strengths relevant to resilience. The CD-RISC also may be used as a screening tool to determine outpatient referrals when a patient is discharged from inpatient treatment or to evaluate emotional readiness for outpatient treatment. Even though we did not identify any examples of researchers using the CD-RISC measure with military personnel, this scale might be used to assess personnel being repatriated. Music therapists using the CD-RISC as a self-assessment screening tool for clients should be aware that there is limited information regarding gender, ethnicity and socioeconomic status in scoring variations. Moreover, its factor structure is unstable and the refined 10-item version might be the preferred version to use in research. In addition, the CD-RISC does not contain any reverse wording items, thus there is the possibility of self-reporting bias.

Child and Youth Resilience Measure (CYRM-28)

Overview

The creators of this measure conceptualised resilience as the ability of individuals, their families and their communities to navigate and negotiate resources in their environment, to have access to resources and to develop meaningful ways to share

resources. In creating the measure, researchers conducted a pilot study using a five-point Likert scale comprised of 58 unidirectional questions. Youth (n=1451) aged 12-23 years from 14 communities (spanning 11 different countries including Canada, China, Colombia, southern USA, India, Israel, Palestine, Russia, South Africa, Tanzania and The Gambia) completed the scale that was translated into their native language. Based on the results, the CYRM was reduced to 28 items (Ungar et al. 2008; Ungar & Liebenberg 2009, 2011). Subsequently, researchers developed four versions of the CYRM-28 suitable for children (aged 5-9), youth (aged 10-23), adults (aged 24 and older) and a version that someone who is familiar with the child/youth can complete (Resilience Research Center, no date). Results from other studies further reduced the CYRM to a 12-item instrument (Liebenberg, Ungar & LeBlanc 2013) and a seven-item simplified CYRM (Montoya et al. 2011).

The CYRM-28 is composed of 28 questions that evaluate youth resilience using a Likert scale from one (does not describe me at all-low resilience) to five (describes me quite a lot-high resilience). Total scores range from 28 to 140 (Daigneault et al. 2013; Ungar & Liebenberg 2011). All but five of the initial piloted 58 questions had means between 3.0 and 3.99 with SD (0.98 to 1.54), which was "enough variability for inclusion in a factor analysis" (Ungar & Liebenberg 2009: 2). The analysis indicated four nested factors: micro/individual, meso/relational community, culture and social context (ecology). Although a valid factor structure on the cross-cultural construct could not be determined using a non-nested approach, this outcome was expected due to the wide variety of cultures represented among the 11 different countries (Ungar et al. 2008; Ungar & Liebenberg 2009). Results in other studies confirmed a three component (1) Individual, (2) Relational (family), (3) Community (context) factor of the CYRM-28 (Collin-Vézina et al. 2011; Daigneault et al. 2013; Liebenberg, Ungar & Van de Vijver 2012; Zahradnik et al. 2010).

The structure of the piloted 58-item CYRM had reliability with the Cronbach's alpha of each construct: 0.84, individual/micro (23 items); 0.66, relational/meso (7 items); 0.79, community (15 items); and 0.71 cultural (12 items) (Lee et al. 2009; Ungar & Liebenberg 2009). The CYRM-28 has internal reliability with Cronbach's alphas ranging from 0.65 to 0.91 (Liebenberg et al. 2012), 0.72 family, 0.79 individual, 0.86 community and 0.78 family, 0.84 individual, 0.64 community (Zahradnik et al. 2010). The total of 28 items had a Cronbach's alpha of 0.90 (Zahradnik et al. 2010) and 0.88 (Daigneault et al. 2013). High interclass correlation coefficients for all three factors ranged from 0.583 to 0.773 and had cross-temporal stability when measured from time one to time two (Liebenberg et al. 2012). Test-retest correlation coefficients at two-week intervals were 0.82, 0.76, 0.84 and 0.73 and three-month 0.75, 0.70, 0.76 and 0.70 for the Total, Individual, Family and Community scores respectively (Daigneault et al. 2013) which were comparable to results in a study by Liebenberg et al. (2012).

Concurrent validity was not established using traditional means of comparing the CYRM-28 with other scales. Instead, the use of interviews and focus group research supported content validity of the CYRM-28 (Ungar & Liebenberg 2011). Face validity of the CYRM-28 was determined through the use of multiple child experts and researchers from around the world (Daigneault et al. 2013; Ungar 2008; Ungar & Liebenberg 2011). The total resilience CYRM-28 score was protective (negatively associated) with PTSD and moderately correlated with exposure to violence (Zahradnik et al. 2010). The French-Canadian version of the CYRM-28 has construct validity because researchers found positive correlation between high scores in CYRM (indicating high resilience) were positively correlated with measures of self-esteem and self-acceptance (Daigneault et al. 2013). The construct validity of resilience was also supported as a negative correlation with PTSD (Zahradnik et al. 2010). Moreover, experiencing multiple forms of trauma was negatively correlated with resilience scores (Collin-Vézina et al. 2011).

Recommendations for uses in music therapy

The CYRM-28 has been used as a measure of resilience of in both clinical practice and in research (Liebenberg et al. 2012). For example, researchers assessed resilience for youth with traumatic experiences (Collin-Vézina et al. 2011) and at-risk youth (Lee et al. 2009). Furthermore, the CYRM-28 results were used as a basis for developing resilience school and public programmes aiming to increase positive emotional development (Lee et al. 2009; Montoya et al. 2011). In addition, the CYRM-28 may be used longitudinally to measure effectiveness of programmes and affect social policy (Liebenberg et al. 2012). The CYRM-28 was condensed to 12 items for use as a screening for resilience characteristics to be included in surveys

that gather a wide amount of data (Liebenberg et al. 2013), although more psychometric analysis is needed for this tool.

In psychometric studies for the CYRM, researchers used large sample sizes (N = 1451, Ungar et al. 2008; N = 843, Lee et al. 2009; n_1 = 589 and n_2= 246, Collin-Vézina et al. 2011; n_1= 497 and n_2 = 410, Liebenberg et al. 2012) increasing the likelihood that results are representative of the general population. Researchers noted that CYRM is intended to be a cross-cultural measure, thus additional psychometric studies internationally are needed to determine cut-off scores (Daigneault et al. 2013; Liebenberg et al. 2012; Ungar & Liebenberg 2011). A specific limitation is that one item of the 28 items may have a negative (instead of the expected positive) correlation, in that it asks about parental supervision. Some youth may view this question as a negative or they may not have parents causing a non-response (Daigneault et al. 2013).

Noteworthy is the purposeful selection of participants in psychometric studies of the CYRM (Collin-Vézina et al. 2011; Daigneault et al. 2013; Lee et al. 2009; Liebenberg et al. 2013; Liebenberg et al. 2012; Montoya et al. 2011; Ungar & Liebenberg 2009, 2011; Ungar et al. 2008; Zahradnik et al. 2010). Such purposeful selection allowed researchers to focus on particular characteristics of participants and answer specific research questions. Because the full version of the CYRM has a mixed methods component (focus interview, panel of experts, developing additional site specific questions) purposive sampling is an essential component of administering this measure.

Researchers claim that the CRYM-28 is short, yet detailed enough to use quickly in the clinical arena and to build on youth's strengths and support those areas that are weak (Liebenberg et al. 2012). The first author of this paper has read the manual of CYRM and has determined that the process of administrating the full measure is complex. The CYRM contains a section in which researchers and clinicians can write their own site-specific questions. In order to develop the site questions the creators of CYRM recommend consulting with an advisory local committee or holding interviews with small groups of people familiar with the individuals who will be completing the CYRM (Resilience Research Center 2013). We believe that the CYRM is a versatile measurement tool. In addition to being used as a screening tool, it is conducive to profiling for intervention because of its global nature of documenting personal skills, peer support, social skills, caregiver relationships, spirituality, education and cultural components. Clinicians may find the CYRM useful for monitoring and measuring change as a result of interventions if they provide music therapy within the auspices of prevention and strength-based programmes with strong components of community and family involvement.

Devereux Early Childhood Assessment (DECA)

Overview

The DECA is part of a suite of assessments that has been expanded to measure within-child protective factors for children ages one month through 14 years (LeBuffe et al. 2013). Because Kaplan Press offers companion pieces for the DECA that are geared towards early childhood educators, researchers have evaluated the use/effectiveness of the DECA programme (Jaeger-Sash 2006; Layburn 2005; Lowther 2004). Researchers have used DECA scores to assess: (a) treatment intervention effectiveness (Dobbs et al. 2006; Perel 2006), (b) how behavioural problems may affect learning outcomes (Escalon & Greenfield 2009) and (c) how presence or absence of protective factors affects the parent-child relationship (Fiore 2008). The DECA is a standardised norm-referenced assessment that measures protective strength-based behaviours and behavioural concerns in children (ages two to five). It is a screening instrument aimed to assess and remediate socioemotional problems prior to developing into disorders. The actual assessment scale is linked to the DECA programme, published by Kaplan Press, which provides several materials for early childhood educators (such as observation manuals, tracking sheets and classroom strategies), targeting and promoting development of within the child protective factors (Reddy 2007).

In order to develop the instrument, LeBuffe and Naglieri (1999a) reviewed resilience literature and identified how children considered resilient behaved. In addition, focus groups were conducted with preschool teachers and parents to give behavioural descriptions of children with good emotional and social health. A preliminary version of the instrument was submitted to the Culturally and Linguistically Appropriate Services programme of the Educational Resources Information Center [ERIC:CLAS] to screen for culturally-biased language. Using this analytic method the researchers created 53 items pertaining to within-child strength-based/protective behaviours that promote resilience. Moreover, the researchers also

aimed to use DECA to screen for problem socio-emotional behaviours. Naglieri, LeBuffe and Pfeiffer (1994), selected 77 problem behaviours by pooling items from five different scales that measured attention problems, emotional control problems, withdrawal/depression and dangerous behaviours. Thereafter a pilot factorial analysis study of the scale was conducted which resulted in further pruning and refining of scale items.

The finalised version of the DECA contains 37 items and has two composite scales: Total Protective Factors and Behavioral Concerns. The Total Protective Factors scale contains three dimensions (initiative, self-control, attachment). Initiative measures the child's ability to use independent thought and action and contains 11 items. Self-control measures ability to experience a range of feelings while engaging in appropriate behaviours and contains eight items. Attachment measures mutual, strong and long-lasting relationships between a child and significant adults such as parents, family members and teachers and contains eight items. Parents and/or teachers of individual children can complete the DECA based on their direct observations in order to create an individual child profile or a classroom profile. Each DECA item has Likert-type answers (Reddy 2007). Further directions on scoring, administration and interpretation are included in the User's Guide (LeBuffe & Naglieri 1999b).

Participants from 95 preschool programmes from across the US, as well as additional parents recruited from advertising in magazines or newspapers in five major metropolitan areas, participated in the standardisation samples. LeBuffe and Naglieri (1999a) stratified the samples, based on demographic data from the US Bureau of the Census, to reflect age, gender, race, geographic region and socioeconomic status. For the strength-based behaviours, some scale items were deleted to retain a total of 27 items that maintained the best psychometric and interpretive solution resulting in a three-factor model. Those factors were labelled Initiative, Self-Control and Attachment. From the 77 problem behaviours items, the researchers retained ten items. Hence, the final version of the DECA measures three protective factors of resilience: attachment (AT), self-control (SC) and initiative (IN). Added together a total composite score was named Total Protective Factors (TPF). The DECA also measures and gives a separate composite score for Behavioral Concerns (BC).

However, there is emerging evidence that even though DECA retains the three protective factors structure, item loadings may not be stable. Lien and Carlson (2009) attempted to acquire validity evidence for the DECA use within a Head Start sample of 1208 children and their parents in a mid-Michigan city. The DECA screening was compared with the current screening tool of the programme, a scale identifying risk factors. The parents completed both scales. In the exploratory factor analysis of the DECA three items loaded onto different factors (Lien & Carlson 2009). Jaberg, Dixon and Weis (2009) sought to replicate psychometric properties of the DECA with a sample of 780 kindergarten students in a rural Midwestern area of the US using both parent and teacher ratings. Confirmatory factor analysis replicated LeBuffe and Naglieri's (1999b) findings, but similarly to Lien and Carlson's (2009) findings, items loaded onto different factors. Noteworthy is that in the studies mentioned above the samples were dissimilar to the DECA standardisation sample, which may explain factorial differences. Other researchers (Barbu et al. 2013; Ogg et al. 2010) also found adequate support for the original factor structure.

The authors of the scale found that alpha coefficient scores for TPF dimensions were 0.91 for parents and 0.94 for teachers. For the remainder dimensions, alpha ranged from 0.71 to 0.90. Test-retest reliability for the TPF score was 0.74 for parents and 0.94 for teachers. The researchers pointed out that teacher-teacher dyads tended to have higher inter-rater reliability because the teachers observed the child at the same environment and time of day (LeBuffe & Naglieri 1999a). Parent-teacher agreement in ratings tends to be moderate (Crane, Mincic & Winsler 2011). Internal consistencies on the DECA for Lien and Carlson's (2009) sample and Jaberg et al.'s (2009) sample resembled those from the DECA standardisation sample.

LeBuffet and Naglieri (1999a) used a comparison group method for conducting three validity studies. For these studies two samples were used: 95 children identified as having socioemotional and behavioural problems and a community sample of 300 typically developing children, referred to as the problem-identified sample and community sample. Minority, sex and ethnicity discrimination biases were ruled out (LeBuffet & Naglieri 1999a; LeBuffe & Shapiro 2004). Moreover, in determining construct validity it was found that children with high risk and high TPF scores had lower problem behaviour scores in comparison to children with high risk and low protective factors. Thus, protective factors, as

measured by DECA moderated the effects of risk (LeBuffe & Naglieri 1999a; LeBuffe & Shapiro 2004). For content related validity, Lien and Carlson (2009) correlated the DECA Total Protective Factors Scale and the DECA Behavior Concerns scale and found a smaller inverse relationship in comparison to the one reported in the original standardisation study; the difference, however, was not statistically significant.

Researchers conducting three independent studies using DECA with Head Start children found that parental reported Behavior Concerns scores were significantly higher than those reported in the national standardisation sample of DECA (Brinkman et al. 2007; Lien & Carlson 2009; Rosas, Chaiken & Case 2007). Results of one independent study with 474 children ages 2-5 attending Head Start affiliated preschools in Delaware, indicated possible gender biases/differences in ratings of teachers. Teachers tended to rate the girls higher across all the three protective factor subscales and lower on the behavioural concerns scale. Parents, on the other hand, rated girls higher than boys only in the Initiative Protective Factor; remaining factors' subscales were scored similarly (Rosas et al. 2007). Gender differences in the DECA norms may need further investigation. The challenge is to identify whether differences exist because of variations in topography of behaviours or because of parental or teacher socialisation processes. Researchers also cautioned that additional studies are needed in determining discriminant validity (Barbu et al. 2013).

Recommendations for uses in music therapy

In our opinion, the DECA has good standardised validity and reliability measures and it is easy to administer and score. The first author has used this measure as a screening tool in early intervention and as a method for guiding treatment intervention in family-based therapy. In general, this instrument might be useful for clinicians as an assessment tool in order to guide early intervention and strategies. It also may be used to assess the effectiveness of overall treatment programming if used as a pre-post-treatment measure. Therapists may find the Devereux Early Childhood Assessment Clinical Form (DECA-C) to be a more extensive tool in assessing socioemotional resilience prior to implementing treatment. The first author is familiar with the DECA-C, but has not used it for clinical assessment. While working as a music therapist in agencies that provided early intervention, family-based therapy and inpatient behavioural health services for children, she relied on information that other related-professionals collected from diagnostic assessments.

Dispositional Resilience Scale (DRS)

Overview

Bartone, a military psychologist, is the author of DRS. He relied immensely on the theoretical construct of hardiness to create items for this scale. Thus, the DRS measures capacity for resilience and focuses on specific personality traits/dispositional attributes that help individuals cope with illness, challenging jobs, or stressful situations. The original version of this scale contained 45 items and was based on the author's doctoral work at the University of Chicago (Bartone 1989). The scale has been revised continually and has four versions; the author allows non-commercial use of the DRS instruments for a licensing fee. Refinement of the scale was the result of studies on stress, health and performance in various groups examining patterns of resilient responding to stressors (Bartone 2008a, 2008b). The final revision was the result of a differential item analysis with samples of US and Norwegian military cadets (Bartone et al. 2007).

The scale contains 15 items; six items are negatively keyed. Bartone (2008a) has compiled normative data for female and male adults and college students allowing conversion of raw scores to T scores for comparisons (Bartone 2008a). The scale has been translated to Norwegian (Hystad et al. 2010), Chinese (Wong et al. 2014) and Italian (Picardi et al. 2012). The DRS15-R has three dimensions that measure hardiness: commitment (consider life and world as meaningful), control (self-determination, believing that a person influences his/her own fate and situations) and challenge (viewing change as an opportunity, seeking new experiences) (Bartone 2008c). The three factor structure was confirmed by researchers (e.g. Sinclair & Tetrick 2000) but cross-culturally, items may load in differing ways (Wong et al. 2014). Researchers using the scale to explore hardiness of employees in different companies found evidence of a unidimensional abridged 12-item scale (Kardum, Hudek-Knežević & Krapić 2012).

Three-week test-retest reliability with a sample of 104 military academy cadets was 0.78 and Cronbach's alpha coefficient values were 0.83 (Bartone 1995), 0.82 (Bartone 2007). The alpha coefficient with a sample of Chinese women was

satisfactory at 0.78 (Wong et al. 2014). Results in several studies exemplify criterion-related validity of DRS. For example, low DRS scores predicted higher incidence of psychiatric symptoms in Army reserve personnel mobilised for the Persian Gulf War (Bartone 1999). DRS can distinguish individuals who have health risk factors from those who do not. In a study with 321 healthy adults working in demanding military related jobs, high DRS scores predicted increased levels of high-density lipoprotein (good cholesterol) (Bartone et al. 2011). Higher DRS scores in a group of US Army Special Forces candidates (n=1138) predicted successful completion of a US special-forces course (Bartone et al. 2008). Regarding construct validity, results in a study indicated a positive correlation between the DRS scores individual characteristics of openness, conscientiousness, positive emotionality and lower psychoticism (Ramanaiah, Sharpe & Byravan 1999). Hystad (2012) found minimal evidence of gender bias in the 15-item version of the scale in that women may tend to rate some items different than men; that tendency did not affect overall results. Wong et al. (2014) found that the total resilience score was negatively correlated with depression. Researchers found that higher scores were predictive of positive affect and fewer subjective physical symptoms (Kardum et al. 2012) and more adaptive neuroendocrinal responses to stress (Asle et al. 2013).

Recommendations for uses in music therapy

The use of the DRS in the literature focused on predicting ability to tolerate stress, negative affect, or selection of personnel who will manage job demands. Participants included both military and civilians. Because of the required fees, we were not able to obtain access to this measurement tool directly. We believe that this scale can be used to examine human organisation behaviour, predict psychosocial adjustment or examine the correlation of personal hardiness and resilient individual responses in work settings or highly stressful situations and predicting adaptation.

Critics of the DRS believe the instrument may be highly related to neuroticism. Hardiness, an attribute considered in measuring resilience, may only buffer stress for adults in stressful work settings, or for adults who engage in considering future outcomes or solutions (Funk 1992). The authors of this paper believe that this instrument does not appear to have been used to measure resilience for clinical or psychoeducational purposes such as assessing response to treatment intervention or identifying individuals at risk for developing psychopathologies. As explained in the background section of this paper, resilience is a complex dynamic construct involving adaptation and growth, not a simple dispositional attitude. A person may exhibit resilient responses in the workplace and not in interpersonal relationships. Thus, the DRS can identify capacity for resilience based on personal attributes and predict resilient individual outcomes, but is limited in scope in that it does not assesses other aspects (such as interpersonal skills) contributing to resilience.

Resilience Scale (RS)

Overview

Wagnild and Young (1993) developed the Resilience Scale (RS) in order to measure resilience as a combination of positive personal attributes that lead to individual adaptation. The scale items were developed by examining data collected through interviews with 24 women who showed healthy socioemotional functioning following loss. Wagnild and Young (1993) identified five personal attributes that lead to resilience: equanimity (appraising one's experiences as part of life), perseverance (persisting against odds), self-reliance (knowing strengths and personal limitations), meaningfulness (having a purpose in life) and existential aloneness (understanding that each person's experiences are unique even though they can be shared with others).

The RS is a 25-item questionnaire with a seven-point Likert scale with higher scores indicating stronger resilience. There are no reversed score items. In the psychometric pilot the mean score was 147.91. Scores above 146 were considered high (Wagnild & Young 1993). The RS has been translated in at least 36 languages (Wagnild 2013). Although the content validity was subjective (results of the qualitative study and consultation with experts), Wagnild and Young (1993) hypothesised the data would fit a five-factor model. Results of the initial psychometric study indicated ambiguity in the loading of factors resulting in two categories. Lundman et al. (2007) were able to confirm a five-factor dimensionality analogous to the themes reported by Wagnild and Young in 1993. Cultural variations to the dimensionality of the RS may exist. For example, results in a study with Russian immigrants failed to confirm a two-factor structure and resulted in a modified 12-item version of the

scale (Aroian et al. 1997). Similarly, in a study with Mexican immigrants, the two-factor structure was not confirmed and resulted in a modified 23-item version (Heilemann, Lee & Kury 2003). Lei et al. (2012) used the scale with Chinese college students who experienced a natural disaster and found that results fit a four-factor model. Researchers have validated a 15-item version of the RS with geriatric population (Wilks 2008), a 14-item scale with general population (Damásio, Borsa & da Silva 2011) and a 14-item scale with college students and individuals seeking mental health services (Aiena et al. 2015). Others have modified the scale to 18 items in order to measure the protective role of resilience in coping with pain (Ruiz-Párraga et al. 2015). Wagnild (2013) recommends using the RS scale as a unidimensional measure.

According to Wagnild (2013) alpha coefficients range between 0.85 and 0.94. In Wagnild and Young (1993) the coefficient alpha was 0.91. In Nygren et al. (2004) test-retest reliability was 0.78. Moreover, in Lei et al. (2012) researchers found the Cronbach's coefficient was 0.94 ($P < 0.01$), split-half reliability coefficient was 0.92 ($P < 0.01$) and the test-retest reliability coefficient was 0.82 ($P < 0.01$). Lövheim, Lundman and Nygren (2012) used the Swedish version of the RS and recommended that a change of 16 points or more on the RS is needed in order to use the RS scale for assessing pre- and post-treatment differences. Researchers using a translated version in Creole found Cronbach's alpha coefficient for the RS was 0.77; the split-half coefficient was 0.72 amongst child and adolescent survivors of the 2010 earthquake. The mean score of the RS was as 131.46 (SD=21.01) (Cénat & Derivois 2014).

In the 1993 psychometric pilot there were no significant correlations between the RS and age, education, income, and gender of responders. Construct validity was evaluated by correlating the RS scores with theoretically relevant instruments. The results indicated that higher resilience scores as measured by the RS were associated with high morale, life satisfaction, better physical health, and lower depression (Wagnild & Young 1993). Similarly, in a psychometric study with 142 adults, 19-85 years of age (Nygren et al. 2004), the RS was positively correlated with measures of coherence and self-esteem. Furthermore, in a study with Mexican immigrants, RS correlated positively with a measure of life satisfaction and negatively with a measure of depression (Heilemann et al. 2003). The RS was compared to the Adolescent Scale of Resiliency Belief System (Jew, Green & Kroger 1999) in a study with 172 Japanese young adults (Araki 2000) focusing on adjustment to the effects of being bullied. The researcher found both scales comparable to each other, indicating evidence of construct validity. Researchers found negative correlations between RS scores and psychological symptoms (Lei et al. 2012). Nygren et al. (2005) found that older adult scores on RS are positively correlated with scales that measure inner strength.

Recommendations for uses in music therapy

Being the first instrument reported in the literature to measure resilience, the RS has had extensive use in the literature. Because it contains no reverse scoring items, self-reporting bias is a limitation of using this scale. In fact, Lundman et al. (2007) have found tendencies to overestimate the RS score. One of the original creators of the scale has published guidance manuals and an updated review of the scale that readers may find useful (Wagnild 2009a, 2009b, 2010). Wagnild and Young (1993) proposed that the RS could measure personal resources that may help individuals cope with difficult life events. The literature includes uses of the RS to measure personal resources of individuals who face: a challenging illness, homelessness, unemployment, or who survived trauma. Researchers who investigated religiosity, spirituality, and resilience have also used the RS. We believe that this scale has consistent psychometric properties, as a unidimensional measure of resilience, and it is straightforward to administer as a questionnaire. Because this scale has specific questions about spirituality it may provide a springboard to address transpersonal meanings. Clinicians may find this scale useful in screening individuals who are vulnerable to poor adaptive outcomes. In addition, clinicians may use the scale to identify clients' inner sources of strength. Researchers may also use this scale to identify differences between pre- and post-treatment.

Resilience Scale for Adults (RSA)

Overview

The researchers developing this scale evaluated resilience as a multifaceted construct. Thus, they sought to measure resilience without focusing solely on individual psychological attributes by including how an individual uses family members

and social support to cope with life stress. They derived their items by looking at literature descriptions of protective factors (e.g. personal attributes, intrapersonal and interpersonal skills) associated with resilience. They categorised the protective factors in a total of 15 categories and created a total of 295 positively worded items. Professors, graduate students, psychologists and laypersons subsequently reviewed those items. The reviews lead to a reduction to 195 items. An additional exploratory analysis led to a development of a pilot scale containing 45 items. The finalised 33-item scale contains both intrapersonal and interpersonal factors relevant to adaptation to adversity (Friborg et al. 2003; Hjemdal 2007).

Previous versions of the scale contained 37-items using a Likert format. The final version of the RSA contains 33-items using a five-point semantic-differential response format alternating the positioning of positive and negative items to reduce bias (Friborg, Martinussen & Rosenvinge 2006). For the semantic-differential version, each item has a positive and a negative attribute at the end of the scale continuum (e.g. easy for me/difficult for me). For half of the items, the positive attribute is keyed to the right and for the other half to the left (Friborg et al. 2005). Such version requires additional cognitive engagement and reduces acquiescence bias, that is, the tendency to respond with a yes or no (Friborg, Martinussen, et al. 2006). The responses for each item are tallied to obtain subscale scores and a total resilience score (Hjemdal, Friborg et al. 2006). There are no gender differences for the total score (Hjemdal 2007). The scale has been translated into French (Hjemdal et al. 2011), Farsi (Jowkar, Friborg & Hjemdal 2010) and Lithuanian (Hilbig et al. 2015).

The pilot version of this psychometric scale included 45-items and a total of five dimensions. The authors had planned to include items identifying locus of control, a construct relevant to resilient outcomes, but those items did not load into the factorial analysis (Hjemdal, Friborg et al. 2001). In the first formal psychometric study, Friborg et al. (2003) contrasted the responses of participants who were scheduled to have their first psychotherapy appointment at an outpatient clinic in Norway to those of a controlled sample. Those who agreed to participate constituted the patient sample; ages ranged from 18-75. The analysis led to further refinement of the items, reducing them to 37. In a subsequent study with 482 applicants to military college (Friborg et al. 2005) added three additional items and conducted additional factor analysis leading to a finalised version of the scale that includes 33 items and six dimensions: (1) positive perception of self, (2) positive perception of future, (3) social competence (i.e. making new friends, comfort in social situations), (4) structured style (i.e. setting goals, planning and organising time), (5) family cohesion (i.e. strong bonds, sharing time), and (6) social resources (i.e. having friends who value, trust and help you). A subsequent study with 201 Norwegian college students confirmed this six-factor model (Hjemdal, Friborg et al. 2006).

The internal consistency of the subscales of the RSA was satisfactory, ranging from 0.67 to 0.90. The test-retest (with a three month lapse) correlations were all satisfactory for the subscales of RSA, ranging from 0.69 to 0.84 ($p < 0.01$) (Friborg et al. 2003). In the revised version of the scale (Friborg et al. 2005) structural equations for estimating reliability indicated alpha ranging from 0.76 to 0.87 for all factors. Results in subsequent studies indicated similar reliability measurements (Hjemdal, Friborg et al. 2006). Friborg et al. (2003) found that RSA scores were positively correlated with the adaptation skills/sense of coherence scores and negatively correlated with a psychiatric inventory score, indicating convergent and discriminant validity. They contrasted the responses between adults with and without psychological problems and found that the differences between the two groups were largest for the personal competence and family coherence dimension. The only reported gender difference was that women tended to have a higher score on the social resources dimension than men did. Their findings indicated that RSA scores can discriminate between healthy adults and those that may develop psychosocial problems (Friborg et al. 2003).

To assess RSA construct validity, Friborg et al. (2005) correlated the factors of the RSA with a Norwegian measure of personality, a measure assessing social intelligence, and a battery of tests assessing cognitive intelligence. Social competence as measured by RSA predicted a more positive social orientation rather than competitiveness. Personal strength (perception of self and perception of future) had a positive correction with emotional stability/lack of neuroticism, perception of future had a strong correlation with conscientiousness. The social intelligence measure was strongly related to RSA-personal strength, RSA-social competence and RSA-social support. No correlational patterns existed between the RSA factors and cognitive

intelligence measures. Overall, personality characteristics accounted for 57% of the variance indicating that RSA is not simply a personality traits/characteristics assessment.

Because individuals with mental health difficulties often show increased discomfort to pain, Friborg, Hjemdal et al. (2006) conducted a predictive validity study of the RSA in relation to pain and stress with 84 healthy adults. The procedure included inducing ischemic pain in a hospital laboratory. The participants completed the RSA prior to the beginning of the experiment. During the experiment, individuals were randomised in a high stress and a low stress condition. Participants in the high stress group received no additional information about the experiment (other than what was included in informed consent) and the experimenter was formal. On the other hand, participants in the low stress group received empathetic comments and were constantly reassured by the experimenter. During the 45-minute experiment, the researchers collected data about perceived pain and stress every five minutes. For pain they used the 10cm visual analogue scale. For stress, they used two adapted visual analogue scales, one using the paired words relaxed-tensed, and the other calm-nervous. The responses on the perceived stress scales were combined to give a composite stress score for each participant. For identifying low versus high resilience participants, the researchers used the total RSA score and used the median as the split point. Results indicated participants in both groups perceived pain and stress as increased during the experiment. For participants in the low stress condition there were no effects on perceived pain or stress. Stated differently, participants responded the same when assessing their stress and pain regardless of their resilience score. For participants in the high stress condition, however, resilience had an overall protective effect moderating pain intensity and perceived stress. Participants with high resilience scores had less perceived pain during the beginning and middle phase, but not at the end. On the other hand, high resilience RSA scores had a protective effect for perceived stress throughout the experiment. In addition to providing evidence of predictive validity for RSA, these results have clinical relevance (Friborg, Hjemdal, et al. 2006)

Hjemdal, Friborg et al. (2006) conducted another predictive validity with 201 Norwegian college students. Participants completed a psychiatric symptom scale, the RSA, and a stressful life event questionnaire as pre-test, and then as post-test three months later. Students who obtained a high score on the psychiatric symptoms scale were not included in the data analysis for the predictive portion of the study. Thus, only the psychologically healthy sample (n=159) was used for the predictive validity of RSA. Results indicated that when exposed to stressful life events at post-test, individuals who reported high levels of resilience remained unchanged, whereas, individuals who reported low levels of resilience exhibited increased psychiatric symptoms. The RSA-total Score, RSA-Social competence score and RSA-planned future score at pre-tests were unique predictors of psychiatric problems mediating the relationship between stressful life events and psychopathology (Hjemdal et al. 2006).

Researchers also examined if RSA, as a psychometric measure, can identify individuals who are more likely to exhibit positive adaptation in the face of adversity beyond existing methods of psychological assessment. For example, individuals with mental health symptoms or a tendency to think negatively are vulnerable to poor psychosocial adjustment. Researchers found that RSA scores can predict susceptibility to poor adaptation both for individuals with affective/cognitive symptoms as well for those who do not. Thus, low RSA scores are not simply indicators of poor mental health but reflect inter/intrapersonal factors that lead to resilience (Friborg, Hjemdal et al. 2009). Contributing to a further understanding of the relationship between vulnerability and mental health researchers found that RSA scores predict vulnerability to hopelessness beyond accounting personality differences, stressful life events, and depressive and anxiety symptoms (Hjemdal, Friborg & Stiles 2012). The results of these two studies illustrate that RSA is a measurement tool that may effectively assess factors related to positive health and predict adaptation beyond merely assessing presence or absence of symptomatology. Moreover, researchers found that resilience, as measured by RSA scores, predicts ability of adults to adjust to the demands of a new job or organisational changes (de Carvalho et al. 2011).

Recommendations for uses in music therapy

We believe that the authors of RSA have followed a systematic approach to collecting psychometric information. They have confirmed and revised the factor structure, identified its relationships with relevant and unrelated measures for convergent

and discriminant validity. For criterion validity, RSA differentiated between participants with psychiatric conditions and non-help seeking controls and predicted development of psychiatric problems. The RSA has promise for applications in health and clinical psychology and is the only scale in the literature that assesses both personal attributes and interpersonal skills. The RSA has clinical relevance because, as Hjemdal (2007: 313) states, it provides support "for a protective model rather than a compensatory model of the measured protective factors". This scale can be used for screening or profiling for intervention. There are no reported uses in the literature of using this scale as a pre-post test for assessing intervention effectiveness.

Resilience Scale for Adolescents (READ)

Overview

Derived from the Resilience Scale for Adults (RSA), the Resilience Scale for Adolescents (READ) was designed as a direct measure that "may facilitate exploration of resilience factors as either compensatory or protective" (Hjemdal et al 2007: 94). Development of the scale began in 2004 following a pilot study exploring whether the semantic differential items would be developmentally appropriate for adolescents. The results indicated that using a five-point Likert-type scale with simplified items that are positively phrased would be more effective. The scale is self-administered and consists of 28 items. There is also a parental version (READ-P) that uses the same items as the adolescent version (Hjemdal 2007; Hjemdal, Friborg et al. 2006). A modified 23-item version also exists (von Soest et al. 2009). The READ scale has been translated in Italian (Stratta et al. 2012).

Similar to the RSA scale, READ consists of five factors named: (1) personal competence, (2) social competence, (3) structured style, (4) family cohesion, and (5) social resources. There are no gender differences with the total score. However, gender differences exist with boys reporting a higher level of personal competence and girls reporting higher levels of social resources (Hjemdal 2007; Hjemdal, Friborg et al. 2006). In 2009, von Soest et al. further explored the validity of READ using a sample of 6,723 Norwegian senior high school students. They created a modified 23-item version of the scale but maintained the same factor structure. Females tended to score higher in structured style and social resources.

Hjemdal et al. (2006) found Cronbach's alpha values between 0.70 and 0.90 for the total score and all the factors. Cronbach's alpha for all items was 0.94, and for the factors it ranged from 0.85-0.69). Similar Cronbach's alpha scores were found in other studies (von Soest et al. 2009). Hjemdal, Friborg et al. (2006) investigated the relationship between READ scores and severity of depression symptoms. A total of 425 adolescents participated by completing the READ and an assortment of measures that provided demographic and personal information. Total READ scores were negative correlated with depression, experiences of bullying, and exclusion/slandering. The personal competence factor had the highest negative correlation with depression. Being beaten or kicked was negatively correlated with the social resources factor. There was a positive correlation between total READ scores and frequency of physical activity outside the school or membership in an athletic club. Participation in team sports had a positive correlation with the personal and social competence factor. Negative life effects did not affect the adolescents' social competence and social resources. However, negative life effects showed a significant negative correlation with the total score and all the other factors.

Similarly, Hjemdal et al. (2007) explored whether READ scores could predict symptoms of depression in young adolescents. Adolescents who scored high on READ reported lower levels of depression, even when controlling extraneous factors such as age, gender, number of stressful life events, and social anxiety. For the adolescent sample in the study, the items of the social competence, social resources, and personal competence were a predictor of social anxiety symptoms; the social competence factor was a significant predictor for symptoms of depression. The researchers noted that contrary to the protective model of the RSA scale, READ scores may fit a compensatory model of resilience. Such a statement implies that the READ may identify positive factors that can neutralise or counteract the effects of risk factors for adolescents. Those factors promote adaptive outcomes regardless of risk exposure. Noteworthy is that READ scores of family cohesion and structured style were not significant predictors of depression. Thus, interventionists may use the results to differentiate treatment for adolescents with depression by focusing on social competence. Administering the READ-P version showed that younger adolescents are a more reliable source of information than the parents regarding scores on the READ and ability

to predict depression.

Moljord et al. (2014) also found an association between high READ scores and lower depression symptoms in adolescents. The findings in this study were important in planning and developing health promotion programmes. Girls with higher physical activity exhibited fewer depressive symptoms; there was no such association amongst boys. Results of the READ scores also indicated that the frequency of physical activity might moderate the relationship between structured style (planning, structure, and daily routines) and depression for boys.

von Soest et al. (2009) used the results from a national survey study with using a stratified sample of Norwegian adolescents for convergent validation of the READ scale. They found small to moderate positive correlations between READ scores, socioeconomic status and school grades. There was a strong negative correlation between personal competence and anxiety/depression. Unhealthy behaviours such as alcohol use, violent behaviour, and being bullied were negatively correlated with READ scores. Hjemdal, Vogel et al. (2011) found that higher READ schools predicted fewer symptoms of anxiety, depression, stress, and obsessive-compulsive behaviours. In adolescents who are screened negative for suicidal ideation, the total READ score correlated with problem-focused coping skills (Stratta et al. 2014).

Recommendations for uses in music therapy

Because the READ has the same factor structure as the RSA, it can be used as a measure in longitudinal studies of resilience (Hjemdal et al. 2007). Researchers have made recommendation for using this scale as a measure of screening and developing a prevention programme (Moljord et al. 2014). The authors of this paper recommend that READ be implemented as a screening tool in order to identify adolescents' exposure to factors promoting resilience. Therapists may use READ as a measure for planning individualised prevention interventions with particular focus of strengthening social competence as well as recommending specific support strategies.

DISCUSSION

Luthar et al. (2000) noted a surge in resilience related literature. That surge is reflected in the emergence of various instruments that measure resilience: 33 out of 50 identified instruments (listed in tables 1 and 2, see appendix) were published within the last 10 years. With so many measurement tools, construct validity concerns, or the extent to which the scores obtained with these instruments relate to resilience versus other characteristics is important. Using instruments to measure exposure to risks or adversity is congruent with the theoretical construct of resilience, which postulates adjustment in one or more domains despite significant threats to adaptation (Luthar et al. 2000; Masten et al. 1990). In this paper our purpose was to conduct a critical analysis of tools developed for measuring resilience for practical purposes (screening, profiling for intervention, and measuring effects of treatment), identify psychometric properties, salient validity or reliability strengths or concerns, and draw conclusions about practical uses in music therapy.

We reviewed a total of seven measures that met inclusion criteria (CD-RISC, CYRM, DECA, DRS, RS, RSA & READ). The CD-RISC, DRS, RS, and RSA are self-report scales appropriate for measuring resilience in adults. The DECA is appropriate for young children (ages two to five); parents or teachers provide the ratings. The CYRM can be administered with children as young as five as a self-report measure. Different versions exist for different age groups. The READ was designed for adolescents and has the same factors as the RSA. Thus, researchers can use READ scores and RSA scores in longitudinal studies. The READ also has a parent rating version. The RSA has semantic-differential items. All remaining measures have Likert ratings. The authors of the CYRM recommend a mixed-methods process allowing researchers and clinicians to add items specific to their sites.

In the measurement instruments we reviewed, the tendency was to either attempt to measure resilience by considering assets and resources within the person or adopting a more analytic process of situating individuals within their ecological environments. The CD-RISC, DRS and RS centre on concepts such as hardiness, perseverance, spirituality and optimism. Even though the aforementioned measures have been translated in other languages and used internationally, they likely do capture sociocultural factors that affect resilient trajectories. The DECA scale also captures characteristics within children who are protective when exposed to adversity. Since the actual assessment is linked to an entourage of materials for early childhood educators, the creators of the scale provide the opportunity of establishing external supports to reinforce development of strength-based skills

within individual children. Furthermore, the family members or caregivers can be directly involved in intervention planning. Adopting a more analytic process, the CYRM, RSA and READ are scales that encompass a broader scope of interpersonal and intrapersonal strengths that affect resilience. Windle, Bennett and Noyes (2011) also recognised the CYRM, RSA and READ as measures that capture resilience across multiple domains.

Regarding specific uses of those instruments in music therapy for screening, profiling for intervention, and monitoring/measuring change, we reached the following conclusions:

(a) CD-RISC: This measure should be administered as a unidimensional screening tool that may provide clinical insight regarding a person's personal qualities relevant to resilience. Researchers may use this instrument to capture treatment effects but need to be aware that this instrument does not have contextual sensitivity and may not adequately capture change resulting from participation in music therapy interventions. The examples we found in the literature indicate that the CD-RISC may capture changes following administration of medications addressing psychological symptoms.

(b) DRS: Music therapists working with individuals who are active military personnel may find this scale useful as a screening tool for triaging who may need additional supports in order to cope with the high demands of their work environments. The conceptualisation of this instrument is based on hardiness and attributes within the person, thus it may not capture resilience across multiple domains.

(c) RS: This measure can be used as a screening tool evaluating an individual's personal resources for coping with life events. It also can be used as a pre-post test in research evaluating treatment effectiveness. Again, we would like to caution readers that this measure lacks contextual sensitivity.

(d) DECA: This measure will be useful for music therapists working in early intervention or family-based therapy. It may be used as a screening tool providing a platform to discuss with parents or caregivers which areas within a child are strengths or may need to be proactively cultivated. Thus, the scale is suitable for intervention profiling. It can also be used as a pre-post test in research evaluating treatment effectiveness. While the measure captures attributes within a child, clinicians may use the results of this assessment as a springboard to plan holistic preventative interventions.

(e) CYRM: This scale seems suitable for screening and profiling for intervention. The music therapist choosing to use this scale will need to be a member of an interdisciplinary team and familiar with contextual dynamics affecting individual clients. The parent version allows for research comparisons, inclusion of caregivers in treatment planning or both. The shorter version may be more appropriate for monitoring changes in response to the intervention. The possibility of adding site-specific questions affords cultural and contextual relevance when administering this measure.

(f) RSA: The comprehensive nature of the six dimensions of this scale will allow music therapists to use it either for screening or profiling for intervention. There are no reported uses in the literature of using this scale as a pre-post test for assessing intervention effectiveness. As previously mentioned, the RSA has a broader scope of conceptualising and measuring resilience.

(g) READ: Similar to the RSA, music therapists may use the self-reported version, or the parent version of this scale for screening or profiling for intervention. There are no reported uses in the literature of using this scale as a pre-post test for assessing intervention effectiveness. Since the READ has the same subscale dimensions as the RSA, clinicians may use this version for adolescents and later transition to using the RSA in order to monitor treatment responses over time.

In general, using psychometric scales to measure resilience can be useful in development strength-based prevention strategies and interventions. Clinicians and researchers, however, should be aware that items in scales might not generalise to different age groups, socio-economic frameworks, or cultural groups. Thus, similar to other researchers who explored uses of psychometric measures to capture resilience, we caution vigilance to avoid emic interpretations of the results (c.f. Reppold et al. 2012; Windle et al. 2 011). Moreover, resilience is a transactional process of learning and development. Thus, current resilience self-report measures only capture positive adaptation patterns that may decrease the likelihood of biopsychosocial maladjustments developing when that individual faces significant adverse conditions.

As Reppold et al. (2012) pointed out, resilience is not an adjustment variable within each individual that represents temporal stability over time. Researchers identified that most measures assess trait variables or individual personal characteristics associate with resilience. They argued that most

measures are limited because individual, historical, cultural, and developmental contexts play a significant role in resilient trajectories (Pangallo et al. 2015; Smith-Osborne & Bolton 2013). Specifically, internal resources included "adaptability, self-efficacy, active coping, positive emotions, master, and hardiness" and external resources within the immediate environment or wider community included availability of "social support and structured environment" (Pangallo et al. 2015: 10). Researchers have even challenged the validity of using resilience measures as indicators of human adaptation arguing that personality scales are a better predictor of avoidance of disturbance (Waaktaar & Torgersen 2010).

We believe that pathways by which personality traits contribute to resilience need to be further explored under the assumption that what may contribute to resilience in one domain, may be a vulnerability or risk factor in another, and that capacity for resilience within a person may increase or decrease as a response to extraneous variables. Resilience is not an innate trait, but rather is something that develops as an individual interacts with their environment. We urge clinicians and researchers who choose to administer resilience measures to carefully examine how the authors of the psychometric tool conceptualised resilience, consider its psychometric properties (validity and reliability), and interpret findings with caution.

A potential limitation of this study is that we did not evaluate each measure against clear criteria but relied more on providing an overview of psychometric measures. Similar to other authors who have conducted systematic reviews, we placed a restriction on the timeframe within which to identify sources. Readers may wish to conduct additional database searches from April 2015 onwards to determine if additional measures have been developed or new evidence supporting the use of the measures reported in this study were published.

In the future, we encourage researchers who use resilience scales to report psychometric information when possible. In addition to conducting additional psychometric studies of existing measurement tools, researchers should perhaps correlate scores between instruments identified in this study. Such will provide additional construct validity results. Moreover, researchers interested in resilience should collaborate across disciplines and join efforts in identifying ways these measurement tools can be used in prevention efforts.

Music therapy clinicians using resilience instruments should keep in mind that obtained scores are not a fixed representation of a person being destined to succeed or fail, adapt or develop psychopathological outcomes. It may, however, provide a snapshot of an individual's capacity for adaptation at a particular point in time. As such, resilience measurement may aid clinicians to proactively address potential obstacles to adaptation through holistic interventions. Clinicians should therefore focus on assets and contextual resources as well as possible underlying environmental and individual differences.

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APPENDIX: LISTS OF MEASURES OF RESILIENCE

Name of instrument	Authors/original study	Theoretical basis/ Measured construct
1. Connor-Davidson Resilience Scale (CD-RISC)	Connor, K. M. & Davidson, J. R. T. (2003). Development of a new resilience scale: The Connor-Davidson Resilience Scale (CD-RISC). *Depression and Anxiety, 18*, 76-82.	Measures resilience in typical functioning adults or adults with mental health problems. It may be used as a post-test in order to assess change following treatment. The focus is on individual characteristics (e.g. hardiness, patience) as well as psychological traits (e.g. attachment, spirituality) that contribute towards resilience.
2. Child and Youth Resilience Measure-28 (CYRM-28)	Ungar, M., Liebenberg, L., Boothroyd, R., Kwong, W. M., Lee, T. Y., Leblanc, J., . . . Makhnach, A. (2008). The study of youth resilience across cultures: Lessons from a pilot study of measurement development. *Research in Human Development, 5*, 166-180. doi:10.1080/15427600802274019 Ungar, M., & Liebenberg, L. (2009). Cross-cultural consultation leading to the development of a valid measure of youth resilience: The international resilience project. *Studia Psychologica, 51*(2-3), 259-268.	Developed through a process of soliciting interviews with youth and adults from countries around the world this instrument measures individual characteristics as well as factors of connectedness to others that support the resilience process. Four versions exist for using the instrument across different ages.
3. Devereux Early Childhood Assessment (DECA)	LeBuffe, P. A., & Naglieri, J. A. (1999a). *Devereux Early Childhood Assessment (DECA): Technical manual*. Lewisville, NC: Kaplan Press.	Measures observable behaviours of children ages 2-5 pertinent to resilience and behavioural concerns. Functions as a screening tool for socio-emotional difficulties that may lead to maladjustment later in life. Assessment is linked with the DECA program, which is designed to identify, address, and ameliorate socioemotional difficulties.
4. Dispositional Resilience Scale – 15 (DRS-15)	Bartone, P. T. (1989). Predictors of stress-related illness in city bus drivers. *Journal of Occupational Medicine, 3*, 657-663.	Developed for use with adults, particularly those engaged in challenging professions (e.g. military cadets), the measure focuses on specific personality traits/dispositional attributes relevant to stress, health, and adjustment.
5. Resilience Scale	Wagnild, G. M., & Young, H. M. (1993). Development and psychometric evaluation of the Resilience Scale. *Journal of Nursing Measurement, 1*, 165-178.	Measures personal attributes that contribute to resilience such as reflecting on personal experiences, understanding personal strengths, finding meaning and purpose in life, understanding that each person has unique experience, knowing personal limitations and not giving up easily.
6. Resilience Scale for Adults (RSA)	Friborg, O., Hjemdal, O., Rosenvinge, J. H., & Martinussen, M. (2003). A new rating scale for adult resilience: What are the central protective resources behind healthy adjustment? *International Journal of Methods in Psychiatric Research, 12*(2), 65-76.	Measures resilience as a multifaceted construct that precludes social competence, personal competence, social support, family adjustment, and dispositional attitudes.
7. Resilience Scale for Adolescents (READ)	Hjemdal, O., Friborg, O., Stiles, T. C., Martinussen, M., & Rosenvinge, J. H. (2006). A New Scale for Adolescent Resilience: Grasping the Central Protective Resources Behind Healthy Development. *Measurement and Evaluation in Counseling and Development,* 39(2), 84-96.	Created based on the research for the Resilience Scale for Adults – adapted for adolescent population. Resiliency Scales for Children and Adolescents (RSCA) (Prince- Embury 2006a, 2006b, 2006c, 2007).

Table 1: List of measures of resilience (meeting inclusion criteria) in alphabetical order

Name of instrument	Authors/Original study
1. Academic Resilience Inventory (ARI)	Samuels, W. E., & B. (2005). *Development of a non-intellective measure of academic success: Towards the quantification of resilience.* ProQuest Information & Learning, US.
2. Adolescent Resilience Questionnaire	Gartland, D., Bond, L., Olsson, C. A., Buzwell, S., & Sawyer, S. M. (2011). Development of a multi-dimensional measure of resilience in adolescents: The adolescent resilience questionnaire. *BMC Medical Research Methodology, 11*, 134.
3. Adolescent Resilience Scale	Oshio, A., Nakaya, M., Kaneko, H., & Nagamine, S. (2002). Development and validation of an adolescent resilience scale. *Japanese Journal of Counseling Science, 35*(1), 57-65.
4. Adolescent Scale of Resiliency Belief System	Jew, C. L., Green, K. E., & Kroger, J. (1999). Development and validation of a measure of resiliency. *Measurement and Evaluation in Counseling and Development,* 32, 75-89.
5. Adult Resilience Indicator (ARI)	Kotzé, M., & Nel, P.. (2013). Psychometric properties of the adult resilience indicator. *SA Journal of Industrial Psychology*, *39*(2), 1-11.
6. Asian Resilience Scale	Liu, X.-l., & Lu, G.-h. (2010). Asian Resilience Scale's preliminary revision, reliability, and validity in Chinese college students. *Chinese Journal of Clinical Psychology, 18*(1), 24-25.
7. Assessment of Core Resilience (ACR)	Shores, E. K. U. (2004). *The development of a measure to assess core resilience in adults.* Unpublished doctoral dissertation, The University of Utah, United States -- Utah. Shores, E. K. U., & B. (2005). *The development of a measure to assess core resilience in adults.* ProQuest Information & Learning, US.
8. Baruth Protective Factors Inventory (BPFI)	Baruth, K. E., & Caroll, J. J. (2002). A formal assessment of resilience: The Baruth Protective Factors Inventory. *The Journal of Individual Psychology, 58*(3), 235-244. Baruth, K. E. (2005). *The Baruth protective factors inventory as a clinical assessment of resilience.* ProQuest Information & Learning, US. Baruth, K. E. (2004). *The Baruth protective factors inventory as a clinical assessment of resilience*. Doctoral dissertation, New Mexico State University.
9. Bharathiar University Resilience Scale (BURS)	Annalakshmi, N. (2009). Probabilistic orientation, Materialism and spiritualism. In A. Husain (Ed.), *Twenty first century psychology: Spiritual perspectives*. New Delhi: Global Vision Publication House.
10. Brief-Resilient Coping Scale (BRCS)	Sinclair, V. G., & Wallston, K. A. (2004). The Development and Psychometric Evaluation of the Brief Resilient Coping Scale. *Assessment, 11*(1), 94-101.
11. Brief Resilience Scale (BRS)	Smith, B. W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008). The brief resilience scale: Assessing the ability to bounce back. *International Journal of Behavioral Medicine, 15*(3), 194-200.
12. College Resilience Questionnaire (CRQ)	Carlson, D. J. A. (2001). *Development and validation of a College Resilience Questionnaire.* ProQuest Information & Learning, US.
13. Devereux Early Childhood Assessment for Infants and Toddlers (DECA-I/T)	Powell, G., Mackrain, M., & LeBuffe, P. A. (2007). *Devereux Early Childhood Assessment for Infants and Toddlers - Technical Manual*. Lewisville, NC: Kaplan Press.
14. Deployment Risk and Resilience Inventory (DRRI)	King, L. A., King, D. W., Vogt, D. S., Knight, J., & Samper, R. E. (2006). Deployment Risk and Resilience Inventory: A Collection of Measures for Studying Deployment-Related Experiences of Military Personnel and Veterans. *Military Psychology, 18*(2), 89-120.
15. Family Protective Factors (IFPF)	Gardner, D. L. B. (2007). *Family resilience: The development of the Inventory of Family Protective Factors.* ProQuest Information & Learning, US. Gardner, D. L., Huber, C. H., Steiner, R., Vazquez, L. A., & Savage, T. A. (2008). The development and validation of the inventory of family protective factors: A brief assessment for family counseling. *Family Journal, 16*(2), 107-117.
16. Family Resilience Assessment Scale (FRAS)	Sixbey, M. T. (2005). *Development of the family resilience assessment scale to identify family resilience constructs* (Doctoral dissertation, University of Florida).

17. Indigenous Resilience Scale	Madeha, N., Saleem, S., & Mahmood, Z. (2010). Development of Indigenous Resilience Scale for Rescue 122 workers. *Pakistan Journal of Psychological Research, 25*(2), 149-163.
18. Inner Strength Scale	Lundman, B., Viglund, K., Aléx, L., Jonsén, E., Norberg, A., Fischer, R. S., ... & Nygren, B. (2011). Development and psychometric properties of the Inner Strength Scale. *International journal of nursing studies*, *48*(10), 1266-1274. . (2011). Development and psychometric properties of the Inner Strength Scale. *International Journal of Nursing Studies, 48*(10), 1266-1274.
19. Measures and Correlates of Resilience	Bowen, D. J., Morasca, A. A., & Meischke, H. (2003). Measures and Correlates of Resilience. *Women & Health, 38*(2), 65-76.
20. Measures of resilience	Hsieh, M. O., & Shek, D. T. L. (2007). Measures of resilience and adaptation of adolescents in single parent families in Taiwan: Psychometric properties and related profiles. *International Journal of Adolescent Medicine and Health, 19*(4), 485-495.
21. Middle School Students' Resilience Scale	Gao, X., & Zheng, R.-c. (2009). Research on three perspectives measurement of middle school students' resilience. *Chinese Journal of Clinical Psychology, 17*(1), 1-4.
22. Multidimensional Trauma Recovery and Resiliency Scale MTRR	Harvey, M. R. (1996). An ecological view of psychological trauma and trauma recovery. *Journal of Traumatic Stress, 9*(1), 3-23. Harvey, M. R., Liang, B., Harney, P. A., Koenen, K., Tummala-Narra, P., & Lebowitz, L. (2003). A multidimensional approach to the assessment of trauma impact, recovery and resiliency: Initial psychometric findings. *Journal of Aggression, Maltreatment & Trauma, 6*(2), 87-109.
23. Multiracial Challenges and Resilience Scale (MCRS)	Salahuddin, N. M. (2009). *Challenges and resilience in the lives of multiracial adults: The development and validation of a measure.* ProQuest Information & Learning, US. Salahuddin, N. M., & O'Brien, K. M. (2011). Challenges and resilience in the lives of urban, multiracial adults: An instrument development study. *Journal of Counseling Psychology, 58*(4), 494-507.
24. Physical Resilience Scale	Resnick, B., Galik, E., Dorsey, S., Scheve, A., & Gutkin, S. (2011). Reliability and validity testing of the Physical Resilience Measure. *The Gerontologist, 51*(5), 643-652.
25. Population-based resilience measures in the primary school setting	Sun, J., & Stewart, D. (2007). Development of population-based resilience measures in the primary school setting. *Health Education, 107*(6), 575-599.
26. Preschool children's resilience in daily life	Takatsuji, C. (2002). Preschool children's resilience in daily life: Creation and validation of a Scale of Reactions to Interpersonal Conflict. *Japanese Journal of Educational Psychology, 50*(4), 427-435.
27. Resilience Development Scale (RDS)	Laird, N. W. A. (2005). *The construction of a measure to assess the development of resilience in adolescents of African descent.* ProQuest Information & Learning, US.
28. Resilience Factors Scale for Thai Adolescents	Takviriyanun, N. (2008). Development and testing of the Resilience Factors Scale for Thai adolescents. *Nursing & Health Sciences, 10*(3), 203-208.
29. Resilience in adults	Strümpfer, D. J. W. (2001). Psychometric properties of an instrument to measure resilience in adults. *South African Journal of Psychology, 31*(1), 36-44.
30. Resilience Inventory (RI)	Noam, G. G., & Goldstein, L. S. (1998). The resilience inventory. *Unpublished protocol.* Song, M., & B. (2004). *Two studies on the Resilience Inventory (RI): Toward the goal of creating a culturally sensitive measure of adolescence resilience.* ProQuest Information & Learning, US.
31. Resilience Scale	Dai, B.-B., Li, J., & Liu, S.-X. (2011). Development of Resilience Scale. *Chinese Mental Health Journal, 25*(5), 385-388.
32. Resilience Scale for Early Adolescents	Baltaci, H. S. & Karatas, Z. (2014). Validity and reliability of the resilience scale for early adolescents. *Procedia-Social and Behavioral Sciences, 131,* 458-464.
33. Resilience Scale for Chinese Adolescents	Hu, Y.-Q., & Gan, Y.-Q. (2008). Development and psychometric validity of the Resilience Scale for Chinese Adolescents. *Acta Psychologica Sinica, 40*(8), 902-912.

34. Resiliency Scales for Children and Adolescents (RSCA)	Prince-Embury, S. (2008). The resiliency scales for children and adolescents, psychological symptoms, and clinical status in adolescents. *Canadian Journal of School Psychology*, *23*(1), 41-56.
35. Response to Stressful Experiences Scale (RSES),	Johnson, D. C., Polusny, M. A., Erbes, C. R., King, D., King, L., Litz, B. T., . . . Southwick, S. M. (2011). Development and initial validation of the Response to Stressful Experiences Scale. *Military Medicine, 176*(2), 161-169.
36. R-PLA: A resiliency measure	Mosack, K. E. B. (2002). *Development and validation of the R-PLA: A resiliency measure for people living with HIV/AIDS (immune deficiency).* ProQuest Information & Learning, US.
37. Singapore Adolescent Resilience Scale (SYRESS)	Lim, M.-L., Broekman, B. F. P., Meng Wong, J. C., Wong, S.-T., & Ng, T.-P. (2011). The development and validation of the Singapore Adolescent Resilience Scale (SYRESS). *The International Journal of Educational and Psychological Assessment, 8*(2), 16-30.
38. Stress Resilience Quotient Scale (SRQS)	Hu, H.-c., Deng, Y.-l., Pan, C., Liang, Y.-J., & Tang, Q.-p. (2009). Preliminary study on Stress Resilience Quotient Scale among the elderly community-dwellers in Zhuzhou City. *Chinese Journal of Clinical Psychology, 17*(3), 318-320.
39. Social-Emotional Assets and Resilience Scales, Teacher rating form (SEARS-T).	Merrell, K. W., Cohn, B. P., & Tom, K. M. (2011). Development and validation of a teacher report measure for assessing social-emotional strengths of children and adolescents. *School Psychology Review, 40*(2), 226-241.
40. Suicide Resilience Inventory–25 (SRI–25)	Osman, A., Gutierrez, P. M., Muehlenkamp, J. J., Dix-Richardson, F., Barrios, F. X., & Kopper, B. A. (2004). Suicide resilience inventory-25: Development and preliminary psychometric properties. *Psychological Reports, 94*(3 Pt2), 1349-1360.
41. Trauma Resilience Scale	Madsen, M. D., & Abell, N. (2010). Trauma Resilience Scale: Validation of protective factors associated with adaptation following violence. *Research on Social Work Practice, 20*, 223-233.
42. Trauma Resilience Scale for Children (TRS-C)	Thompson, M. D. (2012). *Trauma resilience scale for children: Validation of protective factors associated with positive adaptation following violence.* ProQuest Information & Learning, US. Retrieved from http://pqdtopen.proquest.com/pubnum/3458682.html
43. Washington Resilience Scale	Ahn, R. L. (1992). *Development and validation of the Washington Resilience Scale.* ProQuest Information & Learning, US. Retrieved from http://hdl.handle.net/1773/9075

Table 2: List of measures of resilience excluded from the review in alphabetical order

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Article

Flow as a mechanism of change in music therapy: Applications to clinical practice

Michael J. Silverman & Felicity A. Baker

ABSTRACT

Due to the creative and purposeful applications of music in a therapeutic context, music therapists may be uniquely able to foster flow-based experiences for the people who access their services – herein "users". As flow has been linked with a number of positive factors, it may be ideal for encouraging and enhancing learning and therapeutic encounters during music therapy. The purpose of this paper is to describe flow and provide contextualisation of flow in music therapy clinical practice and as a possible mechanism of change that might explain outcomes observed in research with users. To integrate the flow-based literature into music therapy research, we discuss flow in receptive and active music therapy interventions and applications of flow in clinical practice and research. We propose flow as a bi-directional construct in music therapy and, based upon the person-activity fit model, offer a figure integrating skill of the therapist with the challenge of the intervention in an attempt to enhance music therapy education and clinical practice. Moreover, flow may represent a positively framed and less invasive method for measuring users' perceptions of the therapeutic outcomes. Future research utilising all paradigms is warranted to best understand this concept and resultant therapeutic implications.

KEYWORDS

flow, music therapy, optimal experiences, person-activity fit, songwriting, mechanism, change

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INTRODUCTION

In an attempt to understand optimal experiences in human behaviour, Csikszentmihalyi (1975) developed the concept of consciousness where people are powerfully engaged in a gratifying activity. This optimal experience is often referred to as flow. While experiencing flow, a person is highly focused and completely immersed in an innately rewarding task while able to completely ignore distractions. The difficulty of that task is enough to warrant intense focus without boredom or anxiety. This highly engaged and intrinsically motivating state results in an experience where it seems that nothing else matters (Csikszentmihalyi 1990; Jackson & Csikszentmihalyi 1999). During the time of its theoretical development, flow was conceptualised as an alternative to psychoanalytic explanations of the dynamic interaction between the challenge of a task and the person's skills and

abilities (Jonsson & Persson 2006). Flow theory has guided researchers' understanding of the relationships and connections between various tasks, occupations, wellbeing, and life satisfaction. Due to these intersections, it would seem appropriate to apply flow theory to music therapy clinical practice. The purpose of this paper is to describe flow and provide contextualisation of flow in music therapy clinical practice and as a possible mechanism of change that might explain outcomes observed in research with users. To integrate the flow-based literature into music therapy research, we discuss flow in receptive and active music therapy interventions and applications of flow in clinical practice and research. We propose flow as a bi-directional construct in music therapy and, based upon the person-activity fit model, offer a figure integrating skill of the therapist with the challenge of the intervention in an attempt to enhance music therapy education and clinical practice. However, it is first necessary to understand some of the underlying assumptions concerning flow and its relevance in the psychological literature as a positive construct.

FLOW DIMENSIONS

Csikszentmihalyi (1990) noted that flow experiences are characterised by nine dimensions, but that each dimension represents a separate conceptual element of flow. Other researchers have confirmed the nine flow dimensions (Csikszentmihalyi 1993; Jackson 1996; Jackson & Marsh 1996; Martin & Cutler 2002) as well as their construct validity (Jackson & Marsh 1996). These dimensions are as follows:

1. *Challenge-skill balance:* To experience flow, there should be an ideal balance between the challenge of the task and the individual's ability to complete the task.
2. *Action-awareness merging:* When a person is in a state of flow, the person experiences ecstasy and is fully engaged and merged with the task.
3. *Clear goals:* To experience flow, a person must have clear knowledge of the objectives of the task and know exactly what to do. Clarity of purpose functions to keep the person engaged and motivated to complete the challenging task.
4. *Unambiguous and immediate feedback:* To experience flow, a person must receive internal or external feedback that s/he is progressing towards task completion.
5. *Concentration on the task:* While in flow, a person is totally immersed in and focused on the task and extraneous thoughts and distractions are absent.
6. *Sense of control:* During flow, a person has a sense of control over the task at hand, but that control is not absolute.
7. *Loss of self-consciousness:* During flow, a person is freed from her or his inner voice and is thus unconcerned with others' perceptions, fulfilment of others' expectations, and satisfying others' accepted rules.
8. *Time transformation:* During flow, the person's perception of time is somehow altered. Some people report that time seems to stop while others experience time as slowing down or speeding up.
9. *Autotelic experience:* The task a person engages in functions as a reward in and of itself rather than with an expectation of extrinsic gain. After the task is completed, the person feels immense pleasure as all energy during the completion of the task was focused on the task.

THERAPEUTIC IMPLICATIONS OF FLOW

Due to the concept of optimal human experience as it relates to core motivation, Maslow's theory of self-actualisation (Maslow 1968, 1970) was partially responsible for providing the theoretical bases of flow. Self-actualisation can be facilitated by moments when a person is fully engaged in an activity that is intrinsically rewarding. Maslow (1970: 97) proposed that peoples' "healthiest moments" occurred when they fully utilised their abilities, which seems to provide an initial rationale for the exploration of flow as a therapeutic agent. Thus, it seems that flow theory may have implications for health, therapy, and music therapy. Due to the nature of music therapy interventions, it would seem that many users – and therapists – may experience flow within the music therapy experience. However, despite its potential implications and applicability, there is a lack of research literature systematically investigating flow within music therapy settings.

Various researchers have found that flow may be associated with a plethora of therapeutic benefits as a type of peak or optimal experience. For example, Emerson (1998) noted that when a person is in a state of flow, she or he might also experience other beneficial states, including: positive affect, motivation, enhanced cognitive efficiency, and high activation. Increased activation

involves positive aspects that may be conducive to therapy and learning, including energy, interest, alertness, and arousal (Csikszentmihalyi & Larson 1987; Csikszentmihalyi & Mei-Ha Wong 1991). Other authors have articulated that flow may also be related to wellbeing, performance, skill development, quality of life, self-esteem, happiness, leisure, personal growth, life satisfaction, the opportunity of self-actualisation, and other aspects conducive to counselling, health, wellness, and therapeutic experiences (Asakawa 2004; Carlson & Clark 1991; Csikszentmihalyi 1990; Han 1988). In a study examining the relationship between flow and subjective wellbeing in music students, Fritz and Avsec (2007) found several aspects of flow that positively related to measures of wellbeing. The authors therefore concluded that flow was more related to *emotional* wellbeing than to *cognitive* wellbeing. Additionally, due to potential implications for flow in a person's occupational setting, a number of researchers noted that flow theory could be an important therapeutic element in the occupational therapy literature base (Christiansen & Baum 2004; Emerson 1998; Neistadt & Crepeau 1998; Wright 2004).

Rogatko (2009) investigated if engaging in flow promoting activities increased positive affect in university students and found participants in the high flow condition had higher increases in positive affect than participants in the low flow condition. Participants who experienced a greater flow increase also experienced a greater increase in positive affect. Asakawa (2004) also found that flow was related to positive affect in college students. This may result from engagement: As a person is totally engrossed in the task at hand during flow, the person does not have enough attention to be cognizant of anything else (Csikszentmihalyi 1975). During this highly focused state, a person may temporarily be unable to cognize about her or his problems. Thus, the all-encompassing focused attention devoted to intrinsically motivating tasks may offer people a temporary relief from the negative affective state resultant of their problems (or their interpretations of their problems). From a behavioural perspective, a person will desire to return to flow experiences as flow – as well as a temporary inability to be cognizant of problems – is perceived as reinforcing and enjoyable (Csikszentmihalyi 1988).

Warren (2006) noted that Csikszentmihalyi's work concerning flow, despite its congruent intersections and potential applications with art and health, had not been applied to art therapy. Through a case study, Warren observed that art therapy experiences could induce flow as users can fully engage in an intrinsically motivating and rewarding creative experience. The resultant flow can reinforce the self, reduce stress, and provide meaning. Thus, Warren recommended that being aware of flow in the therapeutic context would be helpful to both the user and therapist. Warren indicated that after a person experiences flow, the person has heightened organisation of the self and there is potential for growth. Activities and interventions that result in flow experiences can also provide for a sense of creative discovery. This may result in opportunities for users to engage in risk taking within a safe environment. Warren (2006: 107) noted that the "art therapeutic relationship is also conducive to the occurrence of flow'", which – due to the nature of the creative therapeutic medium – may be congruent with client-therapist relationships formed during music therapy. In a related arts-based investigation studying improvisation and jazz ensembles, Sawyer (2007) explored group-based flow while presenting a model for explaining and fostering creativity in a group setting. In this concept, the group is able to act without thinking and activity is spontaneous. As many music therapists work in group-based settings (Cho 2013; Short 2014), flow theory concept may also be applicable in group-based music therapy clinical practice.

Bakker (2005) investigated whether music teachers' job resources facilitated flow at work and if the flow experienced by music teachers crossed over – via emotional contagion – to their music students. Results indicated that job resources, including autonomy, supervision, social support for colleagues, and performance feedback, were positively related to the balance between skills and challenges music teachers faced. The balance was predictive of the frequency of flow among music teachers. Bakker then found a positive relationship between music teacher flow experiences and student flow experiences, potentially indicating emotional contagion (Hatfield, Cacioppo & Rapson 1994). As Fritz and Avsec (2007) concluded that flow was more related to affective components rather than cognitive components, perhaps music therapists' flow could also be measured. Conceivably due to emotional contagion, flow may be transferred to the users, and flow might then be predictive of therapeutic outcome. Thus, flow may have important ramifications for therapeutic outcome, but additional research is needed. Bakker's results may also have implications for work environments, supervision, social support

from colleagues, and other aspects concerning the self-care of music therapists.

IMPLICATIONS OF FLOW IN MENTAL HEALTH

Implications for the utilisation of flow within various mental health settings are considerable. Csikszentmihalyi (1990) noted that for people who have stimulus over inclusion problems – such as attention deficit disorder (ADD) and schizophrenia – it could be difficult to engage in and focus on a task, which may prohibit flow. Suggesting a potential relationship between flow and psychopathology, Graef (1975) identified similarities between a deprivation of flow and the cognitive disorganisation reported by people with schizophrenia. Massimini, Csikszentmihalyi and Carli (1987) suggested flow might be applicable to psychiatric rehabilitation by including mental health patients in activities that were challenging but not overwhelming.

As there is currently a dearth of psychotherapeutic research as it relates to flow, there are numerous possibilities for future investigations. If therapeutic competence and flow are interrelated, it thus may be interesting to study therapists with less skill and competence and compare them with therapists who are more skilled and competent. Interviews with users receiving psychosocial treatments – including music therapy – may identify differences in skill levels that clinical training directors and educators could use to increase competencies.

FLOW AND MUSIC THERAPY

Various scholars have articulated flow – and concepts congruent with flow – in music therapy. For example, Grocke (1999) wrote about pivotal moments in music therapy while Nilsen (2010) discussed optimal experiences as they may relate to music therapy. Nilsen further noted that music therapy is conducive to flow theory and thus might have the capability to support client health. Fidelibus (2004) completed a dissertation concerning the relevance of flow specific to the clinical improvisation process. During the literature review of her doctoral dissertation concerning flow and music therapy improvisation, Wilhelmsen (2012) articulated the link between empowerment theory and resource oriented music therapy (Rolvsjord 2010). Moreover, Wilhelmsen noted that flow might function as a way to articulate experiences within music therapy and to help understand why these experiences can be meaningful. She concluded that flow might serve as an experience in music that can facilitate health as well as action. Additionally, specific to improvisational music therapy, Wilhelmsen (2012) noted that improvisation could be conceptualised as either active (i.e. wherein the client and therapist are actively taking part in the making of music) or passive (i.e. wherein a client or therapist may be listening to the other and not necessarily making music [Bruscia 1987]). Thus, improvisational music therapy can be categorised as either active or passive and thus could be in either of the following sections.

Flow in receptive music therapy interventions

Csikszentmihalyi (1990) noted that when a person is totally emerged in music *listening*, flow could result. Thus, it would seem that people can experience flow during receptive music experiences such as in music medicine or user-preferred live music (Silverman, Letwin & Nuehring 2016). As it is likely that the song or genre may be the flow-inducing mechanism in receptive music therapy due to the lack of interactive or active therapeutic techniques, this highlights the prominence of the music therapy assessment to determine music preferences to enhance the likelihood of experiencing flow. During receptive music therapy interventions such as listening or improvisation, users may also be cognitively active and engaged with the music experience – and thus in a flow state – despite a lack of overt behavioural indicators that they are actually engaged.

Flow in active music therapy interventions

Due to the nature of flow, active music therapy interventions may sometimes be more applicable than receptive interventions for promoting optimal experiences. Songwriting is an active music therapy intervention commonly utilised in clinical work with a variety of therapeutic settings (Baker 2015). In a non-clinical study by Baker and MacDonald (2013), the researchers found that creating lyrics during a songwriting intervention with university students and retirees did induce flow, but it was stronger when music was also created. Thus, when greater degrees of creativity may be necessary – for example, when users are responsible for composing both lyrics and music – there may be a stronger experience of flow.

Since this first exploration of quasi-therapeutic

songwriting experiences captured measurements of flow, flow as an important mechanism of change in music therapy has begun to enter the music therapy literature. Tamplin et al. (2015) proposed flow and meaningfulness in songwriting approaches could, in their theoretical framework, contribute to wellbeing and a more integrated sense of self in people with acquired brain (ABI) or spinal cord (SCI) injury. Meaningfulness was defined in terms of the users' perceived value of both the process and product of the songwriting and measured using the Meaningfulness of Songwriting Scale (MSS; Baker, Silverman & MacDonald 2016). In their follow-up study measuring the mechanisms of change active in a songwriting program with people with ABI and SCI, strong feelings of flow were reported (Baker, Rickard, Tamplin & Roddy 2015). However, strong feelings of flow did not have a significant correlation with the positive changes in self-concept, flourishing, satisfaction with life, positive affect, reduced negative affect and reduced symptoms of depression and anxiety that were measured. While flow is typically related to positive affective variables, perhaps these constructs are not related in this particular clinical population. However, the degree of meaning experienced by the songwriting process was significantly correlated with negative wellbeing indicators suggesting that songwriting led people with ABI and SCI to reflect on their circumstances which in the short-term led to heightened negative emotions but in the long-term were correlated with positive wellbeing indicators. Perhaps in the case of enduring wellbeing challenges, the impact of positive flow may have had momentary or short-term value and not linked to enduring wellbeing issues.

Flow theory was used to explain why children who had experienced homelessness responded positively to participating in a music performance following their participation in a music therapy program (Fairchild, Thompson & McFerran 2016). Qualitative analysis of brief interview data indicated that children experienced feelings of ownership and empowerment through the performance, pride over the group's achievement, and a connection to audience members (family and friends). Taking flow theory as their point of departure, the authors suggested that children experienced flow through a sense of control, empowerment, and achievement during the performance. They extended these ideas by suggesting that the children's capacity to experience flow was impacted by their availability of coping styles, psychological resources, and external supports. Further investigation is needed, however, before flow can be confirmed as the transformative mechanisms underpinning the children's transformation.

Silverman, Baker and MacDonald (2016) analysed data from two related music therapy studies to determine if flow and meaningfulness of songwriting were related to and functioned as predictors of therapeutic outcome within songwriting interventions for adults on an acute care mental health unit (study 1) and adult inpatients on a detoxification unit (study 2). Correlational and multiple regression analyses were conducted on data with inpatients who had participated in a single-session highly structured blues songwriting intervention with a music therapist. Therapeutic outcomes were state indices of hope (study 1; N = 54 adults on an acute care mental health unit) and readiness to change (study 2; N = 170 adults on a detoxification unit). In both studies, there tended to be positive and significant correlations between flow and meaningfulness of songwriting and therapeutic outcomes, which is congruent with data from Baker and MacDonald (2013). Multiple regression analyses indicated that flow was a significant predictor of therapeutic outcome but that meaningfulness of songwriting was not a significant predictor of therapeutic outcome during both studies. The authors concluded that flow may represent a positively framed and less invasive method for measuring patients' perceptions of the therapeutic outcomes.

Flow as a bi-directional therapeutic construct in music therapy

Anecdotally, it seems that many music therapy users experience flow. They often articulate that music therapy was enjoyable and that time seemed to pass quickly. However, as music therapists, we contend that we frequently experience flow ourselves while providing music therapy. As researchers have frequently studied flow from an occupational perspective (Carlson & Clark 1991; Emerson 1998; Jonsson & Persson 2006; Wright 2004) and our occupations are as music therapists, this generalisation seems appropriate. Thus, as both music therapy users and the music therapist can simultaneously experience flow and it can be predictive of therapeutic outcome (Silverman, Baker & MacDonald 2016), perhaps flow is a construct that is related to working alliance in that it can be bi-directional (i.e. experienced by either the client *or* the therapist or the client *and* the therapist). This concept warrants research attention from a variety of paradigms to better understand and utilise flow and ultimately enhance user experiences.

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PERSON-ACTIVITY FIT FLOW MODEL AS IT RELATES TO MUSIC THERAPY EDUCATION AND CLINICAL PRACTICE

The person-activity fit represents an integral component of flow and refers to the compatibility of a person's skill level in the execution of a task and the level of skill demands that the person experiences during task engagement (Nakamura & Csikszentmihalyi 2002). Skill-demand compatibility is most likely to result in deep task involvement that is intrinsically rewarding that, in turn, promotes a condition optional for experiencing flow. Researchers have found that the compatibility of task demands and a person's skill set is a "crucial causal factor that determines the level of enjoyment and involvement" (Keller & Blomann 2008: 601). If a task is too difficult or too easy, a person can lose motivation, become frustrated, disengaged, and therefore hinder the possibility of flow. In other words, the music therapy interventions need to be sufficiently challenging – but not overly challenging – to engage the user and the music therapist.

Allison and Carlisle Duncan (1988) noted that tasks that a person perceives as repetitive, simple, or tedious can hinder flow and categorised these tasks as anti-flow. Similarly, activities not providing flow may not have meaning or purpose (Rebeiro & Polgar 1999). According to the theory of optimal experience, a person will experience anxiety if she or he does not have the skills necessary to meet the challenge of the task. Conversely, boredom will ensue if the person has greater skills than those required of the task (Csikszentmihalyi 1998). However, if the person-activity fit is "just right" or balanced, then it can result in a person being engaged, motivated, highly on task, and personally invested in the task for intrinsic reasons. Csikszentmihalyi and Csikszentmihalyi (1988: 261) referred to this as the "flow channel". Thus, the balance or fit of the task demands with a person's skill set is a critical factor. Musicians can likely relate to this idea during the longitudinal study of their primary instrument or voice. The music to be learned should be *just difficult enough* to challenge and engage the musician, but the degree of difficulty should be attainable.

The person-activity fit theory may relate well to designing and implementing music therapy interventions in a clinical context. For example, if the music therapist's task for the users is too difficult, the users (and music therapist) may experience heightened anxiety as they are unable to complete the task. Conversely, if the music therapist's task for the users is too simplistic, the users (and music therapist) may experience boredom as the task is too easily completed. Applying the person-activity fit model to the design and implementation of interventions may provide less experienced music therapists with enough structure and guidance to appropriately challenge their users in an ideal manner to engage and motivate them to participate in the intervention.

Relating the person-activity fit theory to therapeutic encounters, Rubeiro and Polgar (1999) articulated that the user – not the therapist – must be the person to define the experience that results in flow. This is congruent with theories involving the therapeutic alliance, in that the client's perception of the relationship is more important than that of the therapist (Busseri & Tyler 2004).

Four- and eight-channel models

The four- and eight-channel flow models were derived from the person-activity fit concept. As this aspect of flow may be considered an abstract concept, it is often depicted using a visual model. In an attempt to categorise the challenge and skill levels required for everyday occupational experiences, researchers conducting studies using experience sampling methodologies identified a four-channel flow model. This model consisted of flow, boredom, apathy, and anxiety depicted in four quadrants. Noting the limitations of a four-channel model, researchers later developed an eight-channel model by adding control, relaxation, worry, and arousal (Jonsson & Persson 2006).

In an attempt to visually depict the person-activity fit model as it relates to creating and refining music therapy experiences, we designed the model in Figure 1. The optimal balance between high skills and high challenges is referred to as "the flow channel" as explained earlier on(Csikszentmihalyi & Csikszentmihalyi 1988: 261.). We developed this figure in an attempt to help music therapists design appropriate and flow-inducing interventions for their service users. Perhaps appropriately including users – who are able to contribute – in the development of interventions may facilitate flow as the interventions can be specifically tailored to meet the users wherever they are. As music therapists are often familiar with the iso-principle (to best meet users where they are *musically*), this concept may generalise to *interventions* including clinical improvisation, therapeutic songwriting, and lyric analysis. It is hoped that music therapists can utilise this model to facilitate flow-inducing interventions for their users and themselves.

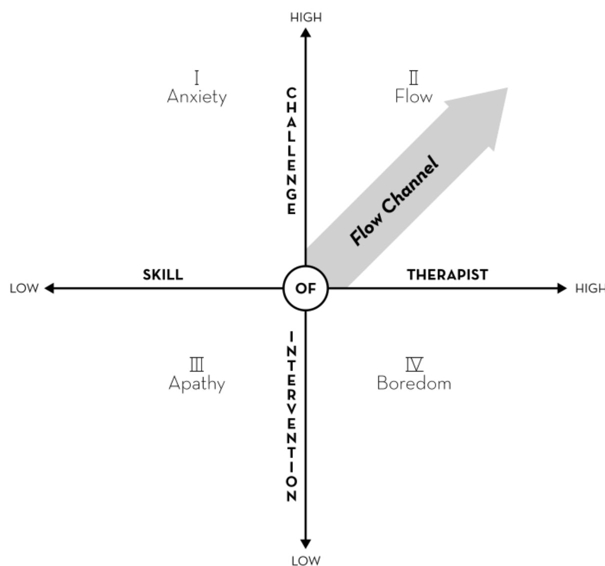

Figure 1: Application of the person-activity fit concept within music therapy

LIMITATIONS OF FLOW THEORIES

While flow experiences can be perceived as a way to improve wellbeing, there can also be "bad flow" (Jonsson & Persson 2006: 63) when flow is addictive. Jonsson and Persson (2006) noted that experiencing too much flow might actually be detrimental to health in that when people organise their consciousness to continually experience flow, important day-to-day tasks and experiences may be inadvertently limited. Jonsson and Persson (2006) therefore articulated the importance of the balance between experiences and occupations, noting that occasional boredom may in fact be a consequential prerequisite for experiencing an altered state such as flow. From this perspective, high challenge tasks should be balanced with low challenge tasks, such as recreation, relaxation, and leisure. Implications for music therapy clinical practice include educating users about engaging in both high challenge and low challenge experiences and tasks so that users are both engaged in challenging and motivating tasks but also not overwhelmed by these as they still engage in tasks that are less challenging.

Another potential limitation is that flow theory does not provide adequate attention to human individuality. Arguing that not all people need to be creative to enjoy the benefits of flow, Reiss (2000) asked if people with cognitive impairments could experience flow. As many music therapists work with people who have some type of limitation or disability, this question and argument may be particularly relevant for music therapists and the appropriate implementation of the person-activity fit model in Figure 1 may be especially relevant. Recent studies indicate that people with cognitive impairments can experience flow (i.e. Baker et al.'s [2015] study of people with moderate ABI and SCI). The question of whether people with significant cognitive impairments can experience flow is an important one. At present, identifying flow in people with significant cognitive impairments is not possible as flow is currently measured by self-report. Therefore, researchers investigating users who are unable to complete self-report instruments due to cognitive impairments are unable to provide data necessary to determine flow as an outcome or predictor of change.

Preliminary neuroscience studies, however, may provide data concerning flow with people with cognitive impairments in the future (Croom 2012; Diaz 2011; Dietrich 2004). For example, it has been suggested that flow may reflect a reduction in brain metabolism (Goleman 1995). Other explanations include neurochemical processes that enable alternation of elation and satisfaction, which also affect cognitive efficiency and creativity (Asby, Isen & Turkel 1999). There is also the suggestion that mesolimbic dopamine activity may also be activated during flow – which provides advance reward information before the user performs the task (Schultz 1998). As neuroscience identifies flow pathways in well populations, we have future possibilities of examining pathways in moderately cognitively impaired people who experience flow (who can self-report their experiences of flow), and then later, with people who are more significantly impaired to determine whether similar pathways are activated during musical experiences.

Finally, Keller and Blomann (2008) found that people with strong internal locus of control experienced flow more than people with a weak internal locus of control. The authors suggested that distinct personality traits and attributes may impact people's ability to experience flow, which is typically characterised with positive affective states. Therefore, this highlights the relevance of the music therapy assessment to screen patients for potential personality characteristics that may impact flow and therapeutic outcome.

CONCLUSION

Although flow may be considered an abstract concept that is difficult to purposely engage in, flow remains a relevant construct that relates to wellbeing, health, and therapeutic encounters. Due to the creative applications of music in a therapeutic context and relationship, music therapists may be uniquely equipped to provide

flow-based experiences for their users. In an attempt to visually depict the person-activity fit model as it relates to creating and refining music therapy experiences, we developed a figure depicting the optimal balance between the therapist's skills set and the challenge of the intervention to facilitate flow from the perspective of the music therapist. As such, flow may represent a highly relevant bi-directional therapeutic construct in music therapy. Additional investigations concerning fostering the flow experience and its applications may be a way to conceptualise mechanisms of change in music therapy, as well as other creative arts therapies. Future research using various data types and paradigms is warranted to better understand this concept and resultant therapeutic implications to best meet the needs of music therapy users.

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Article

Spirituality and music therapy: An action research project in clinical music therapy within the context of an anthropological theory of spirituality

Anita Neudorfer

ABSTRACT

This paper presents a metatheoretical perspective of music therapy under the lens of Karl Baier's anthropological theory of spirituality. As a tool for therapeutic encounter, this theory gives an interpretation of empirical data on the life orientation of Austrian cancer patients in the clinical environment of oncology. The data comes from an action research project as part of a Bachelor's thesis in Music Therapy at the IMC University of Applied Sciences in Krems, Lower Austria. Based in a general hospital, Wiener Neustadt, in Lower Austria, the project took place between November 2013 and March 2014. Music therapy sessions with cancer patients (n=3) were video and audio recorded, transcribed verbatim and analysed. This paper seeks to show how the core concepts of Karl Baier's anthropological theory of spirituality, such as 'situation', 'ground situation' and 'disclosure situation', offer interpretative space for the data.

KEYWORDS

music therapy, humanities, therapeutic encounter, spirituality, spiritual care, life orientation

Anita Neudorfer is an Austrian music therapist and scholar of Religious Studies holding degrees from the University of Vienna in Comparative Religious Studies (BA, MA) and Languages and Cultures of South Asia and Tibet (BA). She dedicated her Master's thesis in Religious Studies to rhythm movement, body culture and the genesis of modern spirituality at the beginning of the 20th century. She studied music therapy (BSc) at the IMC University of Applied Sciences in Krems, Lower Austria where she is currently continuing her music therapy studies at Master's level. As a clinical music therapist, she works in psychiatry and palliative care.

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Author's note: This article is based on a clinical research Bachelor project submitted in 2014 towards completion of the BSc Music Therapy at IMC University of Applied Sciences in Krems, Lower Austria. This Bachelor thesis was also presented at the students' pre-congress seminar of the World Congress of Music Therapy in Krems in 2014 (Neudorfer 2014).

INTRODUCTION AND PERSONAL CONTEXT

Spirituality can be seen as a cultural phenomenon in the midst of modern society (Baier 2012). Former studies in Comparative Religious Studies (University of Vienna) led me during my music therapy internships to question in what way the dimension of spirituality may be observed in clinical music therapy and how such a dimension can be defined and described scientifically without losing oneself in non-clinical applicable humanities or in religious or alternative-religious language.

Drawing on my former studies in Comparative Religious Studies with a special interest in modern spirituality and spiritual care (Neudorfer 2012,

2013) as well as on my own experience in music therapy training and my clinical experiences with terminally ill patients, I found myself put 'on the spot' in certain situations. On one hand, as a religious scholar in an academic environment, I would have argued that music therapy definitely has a spiritual dimension. On the other hand, I realised that such a statement in a clinical context might be controversial. Once, for instance, a student of Health Studies asked me in a direct way: "Do you mean that music therapy is something... *spiritual*?"

When I considered spirituality as a potential topic for research, I received the following reactions from music therapists, which can be seen as symptomatic for the tension between music therapy and spirituality.

> "Spirituality? Is this Haja Yoga?"
>
> "Spirituality... at the end we talk about self-transcendence. That cannot be taught and cannot be decided".
>
> "Spirituality? Where is the practical application? Do you want to make a videography? How can it be measured? *This* is what you have to deal with!"
>
> "Music therapy *has* a spiritual dimension!"

Responses like the above and the intention to connect my background in humanities with my clinical experience led me to this action research project which explores whether academic research on spirituality can serve as a useful tool for clinical music therapy work and as a helpful orientation on a cultural and multifaceted phenomenon called modern spirituality.

My research, as explained in greater detail below, focused on anthropological spirituality in the action field of music therapy. An anthropological-hermeneutic view like Baier's (2012) theory which operates with the keywords 'situation', 'ground situation' and 'disclosure situation' seemed appropriate for this action research, because it afforded a metatheoretical interpretation of music therapy practice.

Following a brief review of the music therapy literature, I focus on Karl Baier's anthropology of spirituality which forms the backdrop for my research. Before that, however, it seems necessary to give a brief introduction to spirituality in clinical context (spiritual care), in order to illustrate the ongoing effort to establish spirituality in health care systems.

SPIRITUAL CARE AS (RE)DISCOVERY OF THE WHOLE HUMAN BEING?

Spirituality may be considered an important characteristic of hospice work and palliative care. The development of spiritual care was triggered by experiences with multi-religious and multicultural encounters. Christian chaplaincy was not able to fulfill these needs any longer. Another factor for the establishment of spiritual care was modernity's tendency towards individualisation in the contexts of religion and spirituality. Europe's generation 65+ is the last one which was socialised in a more or less Christian way. In the successive societies, the majority of people either has no religious-spiritual interests or is dominated by individual ideas without firm ties to an organisation. Individualised spirituality goes hand in hand with a tendency towards self-determination and a distance to institutionalised expert knowledge (Heller & Heller 2014).

Through confronting death and dying from the second half of the 20th century onwards, through hospices and the resulting palliative care, the focus has shifted to death as an existential key for understanding life.

The term 'spiritual care' refers to the (academic) discussion negotiating meaning and importance of death for human life beyond apparatus medicine, symptom control and a fragmented human image. Consequently, studies and theoretical reflections about spirituality in medical and clinical contexts have been established over the past few years. Spiritual care is a relatively young academic discipline at the crossroads of medicine, psychotherapy and hospital chaplaincy (Heller & Heller 2014).[1]

Spiritual care can be recognised by its strong orientation to the subject and personal experiences. This approach stems from criticising a one-sided bio-medical image of man[2] and aims at reconsidering the correlation of body, mind and soul (Heller & Heller 2014).

According to Birgit and Andreas Heller, scholar of Religious Studies and researcher of palliative

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[1] In 2010, the project group 'Spiritual Care in Palliative Care' was founded within the European Association for Palliative Care (EAPC) for researching spiritual care.

[2] The famous words of the founder of modern-day pathology Rudolf Virchow are the epitome of empirical-scientific medicine: "I have performed autopsies on thousands of dead bodies but I haven't found a soul in any of them" (Heller & Heller 2014: 164).

care, we desire humanity when caring for people in need in the form of attention, affection and sympathy, which is –from a religious studies perspective– reflected in the megatrend of spirituality and spiritual care resulting from it. This development is fostered by experiences with apparatus medicine, increasingly differentiated organisations and a rising “reflex-like compulsive need to control” modernity (Heller & Heller 2014: 12).

The integration of spirituality in health care was the topic of the consensus conference, held in Pasadena, California (February 2009). The conference was based on the belief that spiritual care is an essential component in palliative care (Puchalski et al. 2009). Two other Consensus conferences, *Creating More Compassionate Systems of Care* (November 2012) and *On Improving the Spiritual Dimension of Whole Person Care: The Transformational Role of Compassion, Love and Forgiveness in Health Care* (January 2013) were held with the goal of a consensus on the integration of spirituality into health care structures and to develop strategies of compassionate systems of care. Participants echoed the full integration of spirituality into health care, that will create more compassionate, person-centered health systems (Puchalski et al. 2014).

Participants developed a definition of spirituality, which shows the relevance of intrapersonal and interpersonal relationship from an humanistic point of view which is relevant in palliative care as spiritual care in order for a whole-person-care:

> “Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred“ (Puchalski et al. 2014: 643)

Even if the discussion of spirituality in case of sickness and death originated in the field of palliative care, it is now relevant for the entire health care industry (Heller & Heller 2014) and can be also detected in the self-positioning of clinical music therapy in health care.

BRIEF REVIEW OF THE LITERATURE

A flood of literature related to music, therapy and spirituality can be found on the (book and internet) market. But only few scholarly studies describe how spirituality can be defined in a clinical music therapy encounter with patients (for example: Aldridge 1995, 1999, 2000, 2002, 2007; Cerny, Renz & Mao 2005; Lipe 2002; Magill 2007; Marom 2004; McClean, Bunt & Daykin 2012; Potvin, Bradt & Kesslick 2015; Wlodarczyk 2007).

Aldridge strives for a scientific discourse about spirituality in the field of music therapy (Aldridge 1995, 1999, 2000, 2002, 2007). In his article *Beyond Sense: A Transcendental Understanding of Music in Therapy* he describes modern spirituality related to medical practice as an “ineffable dimension that is separate from religion itself” (Aldridge 2007: 293). Aldridge sees spirituality as something that gives meaning and purpose to one’s life. These purposes embedded in the cultural matrix help to transcend what we are. Music can be seen as a force that animates the “dynamic process of transcendence” (Aldridge 2007: 293).

Magill (2007) points out that music therapy promotes spirituality in terminally ill patients by fostering four aspects of spirituality: transcendence, faith and hope, purpose and contentment, and peace. The empathetic presence of the music therapist plays, in addition to music, a key role and contributes to giving back a sense of identity and spirituality in the face of existential hardships.

Timmermann, a German music therapist and psychotherapist, defines music as a gift from gods. Sounds serve better than words for establishing a contact with the beyond, and music is a bridge to “the invisible world of spirits and gods” and reaches into the deepest layers of our unconscious (Timmermann 1998: 7).

Finis describes music therapy as a treatment concept which is heavily influenced by Christianity. Music therapy that is oriented towards Christianity offers a relationship with the Christian God as the creator of the universe and as a positive authority containing the treasures of wisdom. In contrast to certain humanistic worldviews, Finis sees God at the centre rather than man. Therefore, the relationship with God is also the cardinal point in therapy (Finis 2007).

Sutter and Wormit (2007) address the significance of spirituality in the field of music therapy in end-of-life care. Their study showed that spirituality is much valued as an integral part of life by music therapists who work with patients in palliative care but spiritual topics are hardly included in therapies in order to avoid role conflicts. Tasks of music therapy regarding spiritual guidance should be better defined and explored. Music therapists should not replace ministers but act as a link between psychosocial and spiritual needs.

The German music therapist and psychotherapist Baumann also views the music

therapist as a link between psychosocial and spiritual guidance. Together with Bünemann, she argues for an approach based on the principles of palliative care which involves the patient's relatives, addresses the 'spiritual level' and is oriented towards salutogenesis. The authors call their approach "music care". In order to grasp spirituality, Baumann consults the Benedictine monk and Zen master Willigis Jäger, the Dalai Lama and Monika Müller, who is a Christian-oriented psychotherapist. For Baumann, spirituality is primarily a quality available for experience, or a "good spirit" as an attitude towards humans in each person. Spirituality can also be experienced through an interpersonal encounter (Baumann & Bünemann 2009).

Based on Jung's analytical psychology, the Swiss music therapist, psychotherapist and theologian, Monika Renz, places the focus of her work in the palliative care sector on the significance and effectiveness of music therapy and spiritual guidance (Renz 1996, 2003). She defines spirituality as:

> "[…] more than practice. It is experience with the eternal Other. It is not available and ultimately means being deeply moved by the secret of 'God.' In this non-availability, spirituality for me is an event of revelation" (Renz 2003: 28).

Recording spirituality in connection with religion and health in a quantitative way was the goal of Ostermann and Büssing. They developed assessments in order to register the patients' spiritual needs (Ostermann & Büssing 2007). The Austrian religious scholar and philosopher Karl Baier has investigated spirituality regarding its genesis and development (Baier 2006a, 2006b, 2008, 2009a, 2009b, 2012). Locating spirituality in healthcare as spiritual care is one of the research interests of the Austrian religious scholar Birgit Heller (Heller & Heller 2014). Gian Domenico Borasio (2011, 2013), a doctor in palliative care, is working towards the integration of physical, psychosocial and spiritual terminal care in teaching and research. He has also integrated spiritual care within the further education of medical students.

Hilliard (2005) points out the need to create an evidence-based approach to music therapy in hospice and palliative care. According to Wlodarczyk (2007) music therapy can increase the spiritual wellbeing of terminally ill patients.

In the study of Cerny, Renz and Mao (2005) music therapy in cancer care is seen as an approach in an oncology setting which enhances spiritual care. They found that from 251 contacted cancer patients, 135 patients had spiritual experiences in music therapy sessions which had a positive impact on physical and emotional wellbeing.

The study of Potvin, Bradt and Kesslick (2015) focused on the impact of music interventions (music therapy and music medicine) on the management of mood, anxiety, relaxation and pain of cancer patients. The authors found three themes pertaining to deep human experiences underlying the symptoms: relaxation, therapeutic relationship and intrapersonal relation. The study explored the role of clinical music therapy and examined the expanding perspective of music therapy as an holistic approach of symptom management which is defined as "the creative and professionally informed use of music in a therapeutic relationship with people identified as needing physical, psychosocial, or spiritual help" (O'Callaghan & McDermott cited in Potvin, Bradt and Kesslick 2015: 2)

In a qualitative study, Marom (2004) explored music therapists' experiences with spiritual moments in music therapy. Ten music therapists were asked to recall one or two sessions which they would define as spiritual in nature. The variety of defined spiritual moments in music therapy sessions included:

> "[…] moments of major changes in the clients' behaviours; emotions or thoughts; moments of powerful bonding between therapists and their clients, their clients or themselves; moments of strengthened religious beliefs (of clients or therapists) and contacts with transcendent entities" (Marom 2004: 37).

McClean, Bunt and Daykin (2012) explored the relation of spirituality, health and wellbeing with research on the healing and spiritual properties of music therapy in oncology care. The results focus on the four overarching themes of transcendence, connectedness and meaning, faith and hope. The authors highlighted spirituality as a broad-cutting theme. The researchers confirm Magill's understanding of spirituality of four overarching themes: transcendence, connectedness, the search for meaning, and faith and hope.

The approach to the phenomena of spirituality in cancer care requires more research to be undertaken which is recommended by Cook and Silverman (2013), Hilliard (2005) and Lipe (2002).

BAIER'S ANTHROPOLOGY OF SPIRITUALITY

In order to discuss the complex phenomenon of spirituality, an account of the concept of spirituality

at the foundation of this consideration is desirable. Karl Baier, Professor of Religious Studies at the University of Vienna, has developed an anthropological theory of spirituality that creates an understanding of the multifaceted term "spirituality" by way of anthropological reflection. The concept is broad but at the same time it is concrete enough to be applicable to various religions and life orientations of humankind (Baier 2008, 2012).

Baier shows that the term “spirituality” has many meanings. In conservative church circles, it can be understood as returning to a beyond-oriented religiosity (in contrary to worldly matters) while attempting to resist the alleged moral decline of fast-paced modernity. For most people, however, spirituality is the opposite: a tolerant and cosmopolitan alternative to institutionalised religions. What was called "alternative-religious" in the "new religious scene" in the 1960s and 70s, is now a synonym for spirituality (Baier 2012: 65). Sometimes, according to Baier, the sense related to spirituality is stretched so thin “that people consider themselves spiritual when they are interested in Reiki and like to drink Yogi chai” (Baier 2012: 65).

Baier uses and expands the definition of spirituality developed by the theologian Hans Urs von Balthasar. Balthasar’s determination of spirituality as an individual’s practical or existential attitude is based on his religious or ethically-committed understanding of existence. With the help of a hermeneutic phenomenological anthropology, the bodily situatedness of people with their situational world reference comes into focus (Baier 2012), which will be explained more in detail below.

A more detailed description has had to be omitted for want of space and shall be compensated for by a sketch of three key concepts of the theory.

Situation: A body-situated experience of human reality

In the 20th century, the *situation* term gained importance in philosophy, psychology and social science. The subject-object relation was seen as an abstraction because an isolated subject never encounters a single object. Everything that happens to us happens in contexts of situations: we do not behave towards them as neutral objects, but we are within them and go through them, while we relate to something or someone. Situations constitute a meaningful whole and necessarily require from us an opinion, because we are stuck with our body in the middle of them and have to act in some way. As a field of practice they constitute a referential context, which is indeed determined by unchangeable limitations, but at the same time also opens up a margin of possibility (Baier 2008).

Ground situation: About the meaningful life orientation

The *ground situation* is the outermost and largest situation, which forms the foundation of all other situations in a meaningful way and is present in them. As life orientation, the ground situation carries all other situations, even if they are not always perceived consciously. Whether consciously or not, the comprehensive understanding of the world ultimately determines all individual situations in which you find yourself, and suggests certain principles of how to handle a situation (Baier 2008). One can easily imagine people who "act according to a pattern of preference, without being able to call 'last' reasons for their actions," according to the religion-sociologist Thomas Luckmann (1991: 119).

In most cases, the life-determining final orientations based on the understanding of the ground situation are in the dark and cannot simply be listed. Specific maieutics can shed light on those hard-to-reach areas, such as therapy, religious retreats or other ways to come to terms with critical situations and turning points, which make a re-structuring of the ground situation seem inevitable. (Baier 2012).

Due to the situatedness of human experience of reality, even the "last" reality can only be experienced and understood from a situational position. An essential part of the ground situation appearing as ultimate reality is the appearance of its relationship to the world (Baier 2008).

Disclosure situation: Interpreting relations of meaning

The ground situation becomes accessible through the so-called disclosure situations. These typically mean that one participates with a high degree of personal involvement in revealing relations of meaning which are beyond the usual horizon of expectation and skill, normally called “experience of transcendence”, “peak experience” or the like (Baier 2008: 193f; Baier 2012: 28). These moments of interpretation can gain religious importance if an absolute reality is revealed in them for the persons involved. Previous premises of open-mindedness are transgressed and life is put into a new framework. In communication theory, this disclosure can mean the appearance of two solutions (Baier 2012). Through this, people also

discover themselves anew, and unpredictable possibilities of life interpretation and planning open up. This expanded horizon refers to the possibility of a deeper identity:

> "In the history of a past event or a process of here and now […] someone learns something that is speaking to them in a very personal way and that allows a person to discover the core of themselves and their standing in the world" (Schillebeeckx cited in Baier 2008: 193).

Baier's understanding of spirituality is the foundation of this paper:

> "Spirituality can be [...] understood as the practical relation to what is more important to us than anything else. This relation is manifested in rare, intensive experiences but also in life permanently resonating with a basic attitude towards the world which surfaces in certain virtues such as sympathy or mindfulness and, furthermore, through deliberately shaping our existence in the light of what is most important for us" (Baier 2009b: 65).

RESEARCH GOALS AND QUESTIONS

In the tradition of action research and in the role as a practitioner, the aim of this study was to gain an understanding of the term 'spirituality' based on clinical music therapeutic encounters with patients. The intention was not to go deeper into an academic discussion in the field of humanities, but to examine the clinical application of humanities in the action field of music therapy.

The research questions are:

- Is there any interdependence given between clinical music therapy and academic spirituality research? If yes, how does it show in (music) therapeutic practice?
- Does an anthropological approach through the theory of spirituality prove useful and supportive for the practice field of music therapy?

METHODS

This study was undertaken in the tradition of French action research (Desroche) which includes the researcher as part of the research (Prieler-Woldan 1995). That means that during the music therapy sessions I had two roles at the same time: the role as the music therapist and as the researcher. Karl Baier's anthropology of spirituality, as outlined above, serves as the theoretical framework.

The empirical data were collected in the Landesklinikum Wiener Neustadt in Lower Austria. Since 2010, the local music therapist has been in charge of providing music therapy to cancer patients. Music therapy takes place on the edge of the bed and takes an average of 30 minutes depending on the needs of the respective patient. One music therapy session can consist of conversation, using live music, stress regulation or activation. In addition to the human voice the range of instruments includes harp, guitar, oud, monochord, frame drum and Orff instruments which are transported in a mobile instrument box through the hospital.

Depending on, and defined by the duration of the stay of the patients (one to five weeks), music therapy encounters take place on average one to four times, depending on the weekly internships. The psychosocial staff of the hospital comprises three psychologists, one music therapist, one chaplain and one mobile palliative team.

Music therapy sessions with patients (n=3) were documented in internship logs, tape-recorded, transcribed verbatim and analysed by means of descriptive text analysis (Assing 2012). Statements of patients were compared with and seen under the hermeneutic-anthropological lens of the spirituality theory.

Selection criteria

From November 2013 to April 2014, 34 cancer patients were documented in internship logs. Of these, six music therapy interventions were video- and audio-recorded with the patients' consent. Patients were selected on the basis that they had been oncology patients referred earlier to music therapy and that it should be possible to communicate with them verbally. They gave their consent to video- and audio-recording. In addition to music, the intervention included a therapeutic conversation. Out of the six sessions that were video- and audio-recorded, three could not be considered for the project: after one encounter no therapeutic conversation took place because the patient fell asleep, the sound quality of one video recording was not sufficient for further consideration, and the third was analysed too late to be considered. This left three patients with one recorded therapy session each. The names of the patients were made anonymous by replacing their names. Table 1 gives an overview of the music therapy sessions and recordings.

	First contact	Second contact
Patient 1: Mrs Franz	Video recorded	-
Patient 2: Mrs Ludwig	Internship log	Video recorded
Patient 3: Mrs Gross	Internship log (This music therapy session was provided jointly by my internship colleague and me)	Audio recorded

Table 1: Overview of music therapy sessions and video/audio recordings

Descriptive text analysis

The procedure of comparing music therapy with spirituality theory used here was a text analysis. The video- and audio-recordings were evaluated by means of descriptive text analysis (according to Assing Hvidt et al. 2012). The left margin of the transcripts was used for highlighting characteristic or noteworthy remarks, especially if these referred to an orientation of purpose in life. This process of basic coding was performed for the entire transcript, paying special attention to what the patients said (Bryan 2001). Following this step it became clear that the spirituality theory was very appropriate for further analysis. The transcripts were read against the selected framework by making notes in the right margin which make the connection to the theoretical concept. Consequently, this strategy for analysis could be labelled as deductive (Assing Hvidt et al. 2012: 38).

To enhance the phenomena of spirituality it was important not to reduce the empiric utterances to confirming illustrations of the selected theory but to read and analyse them each by themselves. Furthermore, it was essential to show in which (linguistic) way the patients expressed themselves about the situation and how they stated their needs. Therefore, paraphrasing was avoided wherever possible in order to indicate the illustrative and singular value of their words.

PATIENTS' NARRATIVES

The following section describes the therapy sessions of three patients in a narrative way and is concluded by allocating them to the key concepts.

Patient 1: Mrs Franz

First contact

Mrs Franz has uterine cancer. She is friendly and seems tired. She talks about her disease. After listening to harp music played live, she whispers: *"Very beautiful, very beautiful."* She asks for the purpose of *"this type of music"* (it was an improvisation) and says it is a nice experience. She finds it, however, difficult to concentrate due to having many thoughts in her head. She feels some inner pressure due to the disease. In order to find out, what kind of resources helps Mrs. Franz, I ask her, who or what she really likes or liked in her life. Mrs Franz names a child, grandchildren and friends. She describes the loss of hair induced by the disease. She then asks me if I am married.

As an aside, I mentioned at the end of this music therapy session that we celebrate our patron saints on the same day because we have similar first names. Then the patient says that her husband died on the day of our patron saint. What follows is a conversation about true love and about the fact that now that she thinks about it more. Mrs Franz has reached the conclusion that a *"good life"* is not necessarily *"beautiful"* but one's heart has to be open.

Patient 2: Mrs Ludwig

First contact

Mrs Ludwig is a palliative patient with uterine cancer. She is alone in a room with two beds. *"The cancer won't get me"*, is her motto. She has to be strong, then everything will work out, in that sense, that with such an attitude, the cancer will not prevail over her. She has a lot to do with body work and massage. Therefore, I suggest a guided imagery trip towards relaxation through the body, accompanied by an ocean drum and singing. For the receptive music, Mrs Ludwig states that she was able to relax very well, that she was visualising images and was on "her journey": a planned holiday by bus with some girlfriends which had to be cancelled because of her hospital stay.

Mrs Ludwig mentions the window of her hospital room which is protected from pigeons by a net. On considering the net, she says that she can understand why *"surely a few people would try to jump out"*. Would she consider this? No, not her, *"[…] not because of 'something like this' – one has to be strong!"* Mrs Ludwig starts telling every detail about the above-mentioned bus trip breathlessly.

Due to her hospital stay, this trip was not possible anymore; although she had organised it all she had to cancel and the travel agency was giving her a hard time. In addition, one of her friends now has cancer as well and does not want to go on the trip without Mrs Ludwig.

Second contact (two days later)

Mrs Ludwig has just returned from radiation therapy and seems tired and introverted. She describes being admitted to the hospital and asks for harp music. She closes her eyes, her breathing slows down. After the receptive music, she starts to talk about her holiday. When she refers to solidarity among her girlfriends, Mrs Ludwig starts to cry because she has often cancelled walks with her friends without thinking much about it. After a call from her daughter it turns out that Mrs Ludwig feels the need to talk to her family about dying but they refuse to listen to her. Mrs Ludwig also has thoughts about her funeral; she could imagine an urn but her husband is against it, she should be buried in the family grave. We are laughing about the idea of being turned into a diamond. This is followed by a receptive period of ocean drum and singing.

Patient 3: Mrs Gross

First contact

My colleague and I go to Mrs Gross, a palliative cancer patient in a room with six beds. The daughter, a young adult, is with her. Both listen to music with one headphone each. When we introduce ourselves as music therapists, Mrs Gross says that music therapy is what she has actually spent her whole life with. We then ask her if she is a music therapist. *"No"*, she answers, but she is dealing with *"heart music"*[3]. Mrs Gross is pondering how to bridge the gap between reality and hope.

My colleague and I play receptive harp and guitar. Through the music, the atmosphere in the room changes. Mrs Gross seems very quiet as if listening to her inner thoughts. Afterwards she says with a very calm voice: *"Thank you, this has touched me"*.

Second contact (one day later)

One day later I go to see Mrs Gross alone. She seems upset and has to tell me something important regarding what happened during yesterday's music intervention. First of all, the music touched her very much yesterday, something has changed. In the evening, she realised what it was; the forgotten childhood experience of being locked into the basement by her mother. I told her that that moment yesterday was also very touching for me. Mrs Gross starts to cry. We talk for a long time and at the end I play harp for her. Mrs Gross has her eyes closed for most of this. She looks tired and falls asleep several times while I play. Despite the presence of other patients and visitors, the whole six-bed room is quiet during and after the music. A nurse comes in and calls a name very loudly. Everyday noises fade back in.

ILLUSTRATIONS AND FINDINGS OF *SITUATION* IN MUSIC THERAPY SESSIONS

The findings of these music therapy sessions are presented below. The emerging themes are further explored in the discussion section.

Mrs Franz (Patient 1) says after receptive harp music that her disease makes her think a lot. Looking back at her life during her hospital stay, she recognises the structure of actions in her life. There were no "great goals" that she and her husband had ever pursued. But she feels happy with her life and the way she had designed it:

> I had to think a lot recently. He was always happy and I am happy too, we don't have such 'big goals', that have, I have never, never, never, no, I have got […] Yes, well what other people strive […] we, we just got! When I think now![4]

Mrs Franz sends me away with words which describe her being at peace towards life and death*:*

> Keep your eyes open! Could be in the supermarket, on the tram somebody picks up a piece of paper, you never know (i.e. when you meet your true love)… it's like death, you never know when it comes!

Not only "being at peace" with life but also various needs steer the situation of this music therapy session in a certain direction. Mrs Ludwig (Patient

[3] Various providers offer transforming the heart rate variability into music with a special computer programme, for example in a harp melody. Mother and daughter have each received their own "heart melodies" this way.

[4] Note that the patient's first language was not German so the original as well as the English translation are a bit choppy.

2) had also considered different funeral options which was a taboo topic in her environment:

> Cremation, right? It might be modern though but I just saw on TV how they put you into an oven, well… I don't know […] I also used to say I want to be cremated and you'll keep me at home.[5] And my grandchild says, "Granny, then I won't come to that house anymore!" […] She said she won't come anymore when she knows that I'm sitting there. I don't want that.

We both laugh in a liberating way about the many funeral options, for example being turned into a diamond instead of being buried.

In contrast, with Mrs Gross (Patient 3) the situation does not show itself through describing the disease but through looking back at life.

> Because I was there for everyone, day and night and completely forgot that… *(pause)* to do something for myself. […] always thought I had to save the world *(pause)* and now the world also keeps spinning, even if I can't do anything, no. Yes. *(pause)* I got into that too deep, to take life too seriously, no.

FINDINGS

The findings below are presented with a focus on *ground* and *disclosure situation* drawing on Baier's anthropology of spirituality.

Ground situation in music therapy

As explained above, the ground situation is the outermost and largest situation, which forms the foundation of all other situations in a meaningful way and is present in them. As life orientation, it carries all other situations, even if these are not always perceived consciously.

On the question of what was important in her life (ground situation), Mrs Franz (Patient 1) did not mention her husband and her happy marriage of 32 years. This was mentioned only later by coincidence when we noticed that we had similar first names. Mrs Franz then answered that her husband died on the day on which our patron saint is celebrated and started talking about the 32-year love relation to her husband as *"something unique in this world"*:

> That was very nice. We felt so great, we were holding hands and felt the wind. We could accomplish anything. And we defined our goal. What goal? Everybody needs some kind of goal, why do you save money or go to work […] we didn't do anything. When we were happy, we may, I worked until 2pm, he worked until 2pm […] we had a great time, really great. Yes, yes, yes aha.
>
> Yes! This was true love. It was. […] We looked at each other, we knew where we were going. We always knew without any words, you know, that is something, that is something unique in this world. This, this doesn't happen often.

Due to the (situative) condition in which I encountered Mrs Franz and how she talked about her sickness, she appeared happy regardless of her sickness and pain. I gained the impression that the way in which Mrs Franz came to terms with her situation was motivated by being in a happy relationship for 32 years:

> Now I have everything behind me, the children have grown up […] I'm telling you, I have a beautiful life, you should also look for the real thing! It doesn't have to be pretty but good, it has to be a good one […] the hearts have to be open!

Right after this, Mrs Franz mentioned the passing of and bidding a final farewell to her spouse, in which the acceptance of death and impermanence was recognisable.

> But on the last, second to last day, he still hugged me, said goodbye in a nice way. Very, very, very, very, very ehm emotional was this. So tight, so, so tight, so tight holding […] Yes. I am waiting, I am waiting for this [i.e., the husband's imminent death] But the professor didn't know but I know that, that it will come.

Triggered by this, the patient showed an altruistic attitude combined with uncertainty and acceptance of one's own mortality:

> He was also just asking, have we sold the house? I said no. Oh well, then save it for the little ones, for the grandchildren. Well, now, now they have the house for the little ones because I promised to keep it for the little ones. But it's only

[5] From the point of view of religious studies, Mrs Ludwig is addressing an interesting issue here: the idea of identity and the beyond. On the one hand she implies "not being around anymore" after her passing, on the other hand should she (she talks about her physical remains in the first person) be stored at home. The question comes up: who or what is actually dying? In the light of ideas of heaven and hell devoid of meaning and the lapse of confessional ideas about the beyond, the question of what comes afterwards is sometimes hidden behind the considerations of funeral options (Neudorfer 2013).

> ten [i.e. years]! Another eight years still and I don't know if I will be able to help that long or not.

Losing the autonomy over her body revealed the underlying ground situation in Mrs Ludwig (Patient 2):

> When I only remember how I went walking, I always told my friends, "Today I don't feel like going, today my back hurts a little" or "No, I don't have time today." And then I thought, why do I always make up such excuses? *(pause)* I can't… I don't even manage to *(cries)…* I can't go walking anymore.

Mrs Ludwig's loss of identity "I can't go walking anymore" expressed the underlying desire for community with the group of friends who were very important for her.

> I told my friends: "You don't have to stay here with me, why don't you go down and look at that." Well, impossible: all of them stayed, all three of them, none left!! All three of them sat with me and said, "Let's head back."

During the conversation, Mrs Gross (Patient 3) expresses her ground situation using the following words:

> I – I am convinced that everything is connected to everything. Some things you can perceive better than others.

Disclosure situation in music therapy

For Mrs Gross, the biggest part of the music therapy session was verbalising yesterday's experience which consisted of receptive live music featuring harp and guitar. It turned out to be a disclosure situation, triggered by the therapeutic use of live played music.

Here the patient is excited and describes what yesterday's receptive music therapy has triggered within her. The quotations are given below in chronological order. For better understanding, some of the words Mrs Gross uses to describe the disclosure situation are typed in bold in order to illustrate that Mrs Gross is talking about "the point" here:

> My life! *(pause)* That's why **it** [the individual experience during a receptive intervention in music therapy] surprised me so much, why I can't get to that point, no. Oh my – once I almost drowned as a child, I went through a lot and thought by myself, actually these are near-death experiences. I had those twice but **this** totally startled me now… that I wasn't able to get to this, no.

> *(Under tears):* Yes, **it** was very strange. *(pause)* Because I didn't expect **this** at all, because well, I've got a pretty crappy diagnosis but I stayed perfectly calm [during yesterday's music]! I just want to *(pause)* live on.

Mrs Gross is describing now how she turned towards her own inner self through the receptive music:

> But I can take it the way it is, yes. Yesterday, **that** really – *(long pause)* **that** really amazed me. And then in the evening I was, well, I turned off the light at eight and thought by myself, I'll go inside now and wait what will come, and noticed there was excitement, I couldn't breathe and then all of a sudden it was c-r-y-s-t-a-l c-l-e-a-r *(pause)* what happened there.

Relationship-oriented music as an aesthetic trigger of emotions – such as utilised in the work of music therapists – turned out to be a disclosure moment for this patient.

> And – I have, when you play as a child that everything is OK, it seems much too long so I used to scream out the window. Once she came home and smacked me, so she was desperate, yes? And that, that's not it, but at some point she must have locked us into the basement. And that was it, yesterday **this** completely *(pause)* I really noticed that there is some very deep pain.

Simultaneously, talking about this moment brings patients to a level of self-distancing, from which previous strategies become visible and carry the potential of transformation:

> Eh, I was paralysed! And then I have the feeling, but I don't know whether it comes from the head, whether it really *(pause)* I have the feeling that when I tell someone then *(pause)* she will lock me in again. I locked that away *(pause)* that, I mean, I cannot go into my mother, I had a very difficult relationship.

As mentioned above, the life-determining final orientations based on the understanding of a ground situation are in the dark in many cases and cannot simply be listed (Baier 2008). Living through her childhood memories again caused Mrs Gross great pain which she had felt all through her life but had been unable to locate where it had come from.

Mrs Gross explains how this disclosure moment triggered by a music therapeutic intervention

(receptive music) could result in a restructuring of her ground situation.

> And I think, now I'm lying here for a week, for one week they haven't done anything with me. I am thinking the whole time, probably it makes sense on some level, no. And I'm really speechless because so many things have come up that I'm thinking the bigger picture is changing again as well, no.
>
> Yes, a new space opened up really. And in new spaces, there are also different solutions, one also has to see that, no. Places you wouldn't have been able to reach earlier, where you… that were inaccessible to you. This is an aspect I do believe in. That depends.

DISCUSSION

Through discussing and exploring these findings further, it turns out that none of the patients mentioned spirituality by name. Table 2 illustrates examples of the topics indicated by patients in the context of clinical music therapy and connects them to the anthropology of spirituality.

What is important for the patients, what is significant and what is abhorrent, what they feel connected to, what causes them pain, what they wish for and how they interpret their lives – this forms a basic reality. Such utterances do not just reflect feelings or the mental workings of a person, but existential views from which he or she encounters their surroundings and interprets them, as can be seen in table 2.

Ground situation or disclosure situation are not visible in each music therapy session, as can be seen in this study. In particular, disclosure situations cannot be planned. Given the small numbers of recorded therapy sessions it was mere luck that Mrs Gross experienced such a deep disclosure moment through receptive music and also verbalised it.

From the initial situation in which the music therapist finds the patients, an enquiring and empathetic therapeutic attitude is required. It was being oriented towards the patient that brought both the patient and the therapist together to current and often existential topics. Receptive live music was used as an intervention for all three patients. In the role of the music therapist I adapted melody and pace to the intersubjective atmosphere in the therapeutic relationship and to the patient's rhythm of breathing. All three patients shared experiences, memories or thoughts verbally after listening together.

Situation	Disclosure situation	Ground situation
Relation to life & death: "You never know when it comes (the big love)…is like death - you never know, when it comes." (Mrs Franz)	**Experiencing old pain:** "My life! That's why it surprised me so much, why I can't get to the point." (Mrs Gross)	**Connectedness:** "Everything is connected to everything!" (Mrs Gross)
Needs: Want to talk about death and dying (funeral considerations) (Mrs Ludwig)	**Self-distance as Self-transcendence:** "I know, I've got a pretty crappy diagnosis, but I stayed perfectly calm! I just want to live on!" (Mrs Gross)	**Altruism:** Meaningful assistance for "the little ones" [grandchildren]: "Another eight years still and I don't know if I will be able to help that long or not." (Mrs Franz)
Reminiscing through looking back at one's life: "Always thought I had to save the world (pause) and now it keeps spinning, even if I can't do anything." (Mrs Gross)	**Opening new horizons:** "In new spaces, there are also different solutions!" (Mrs Gross)	**"Good" Life:** "Life does not have to be beautiful! It has to be good – good! Heart has to be open!" (Mrs Franz)
When ground situation disappears: "Cannot go jogging anymore!" Lack of community, autonomy and life. (Mrs Ludwig)	**Restructuring ground situation:** "Probably it (cancer) makes sense on some level. (…) So many things have come up, that I'm thinking the bigger picture is changing again." (Mrs Gross)	**"Everybody needs some kind of goal":** "We felt so great, we were holding hands and felt the wind. Everybody needs some kind of goal, why do you save money or go to work." (Mrs Franz)

Table 2: Situation, ground situation and disclosure situation

In a therapeutic relationship, music does not only serve as a trigger for emotions, but also as a guiding sign towards the patient's horizon of interpretation and, consequently, for turning towards the inner self. Live music in a music therapy setting has the potential to connect to the patient's mood. Receptive music, therefore, is not just meant for "relaxation", but serves for turning towards the inner self. Furthermore, this calls for focusing on the process as the therapist's other basic quality.

In accordance with the Austrian music therapist and anthropologist Gerhard Tucek (2014), one can recognise two types of shared characteristics behind the various patterns of disease: by means of the taxing situation of a basic disease, uncertainty about the process of sickness and healing, but also the frightening conditions in a clinical setting, patients are under heavy pressure. Therefore, the first goal of therapy should be to offer a (non)verbal, musical relationship in which the patient can relax (Tucek 2014). Against the background of life-threatening situations, questions of purpose and value come up, as well as the desire for connectedness, transcendence and coherence. Identity structures, meaningfulness and survival patterns play important roles here: *"Do I feel connected with life (the way I lead it), understood by the people who play a part in it, and carried by a higher instance?"* (Tucek 2014: 140).

In the light of the recent efforts of music therapy and impact research, Baier's anthropological lens could provide a theoretical background, which helps to interpret and explain therapeutic encounters in music therapy.

CONCLUSIONS

As a social place, the hospital is a focal point of our society where the engine of work and consumption grind to a halt for the patients: when it comes to disease, death, emotional conflicts, loss of identity or moments that stir you to the core. In a clinical context, elements of the anthropological theory of spirituality can serve as backgrounds of music therapy interventions.

Combining practical experience with an anthropological approach to spirituality leads to the insight that everyday small talk about weather, patron saints' days, children or hobbies may contain coded information about the patient's inner world. In many cases, these are not manifested directly and explicitly, but implicitly. Embedded in a therapeutic relationship, live and patient-oriented music is an excellent medium and can serve as a trigger, a door opener and a signpost for traces into the patient's inner world. To say it with the words of Sir Simon Rattle in an interview for the film *Rhythm Is It* (2004), "music is not just what it is, but is that what it means to the people".

During the course of this study, it was crucial for a therapeutic understanding to consider the relationship between sense and identity. Sense and identity require one another. The concepts of life and self in the foreground (identity) reflect moods in the sense of value and ultimate life orientation (background). A music therapist does not only enter the patient's room as an external space belonging to the patient but at the same time he also touches their *situation* (according to Baier) and with this, the music therapist also encounters their inner space. This inner world also contains the human-existential dimension which is part of the existential negotiation of sickness, pain and death as a body-situated and also as a human experience.

The encounter on this level is one of the aspects of music therapy. Not every music therapy encounter takes place on this level and yet it happens from time to time[6]. The practice of encounters such as those experienced in clinical music therapy has the potential to touch a human-existential dimension. Human striving beyond material existence falls under spirituality in the academic discourse. In the body-situated experience of the fact that death and dying do not only concern them (anymore), existential questions face one's own mortality in direct confrontation.

As mentioned above, many patients do not express themselves explicitly when it comes to such basic definitions. It cannot and should not be the task of music therapy to wait for seriously ill patients to finally start talking about their existential level. An empathic awareness and knowledge of this aspect by the therapist can, however, contribute to providing a solid and resonating foundation for the patient, and to recognise such traces for what they are.

Furthermore, (or rather hidden within), caring for the patient takes on a special role on the human-existential level. This level is basically inseparable from the others and yet it makes sense to investigate it explicitly, as a music therapist and as a human encountering other humans.

Experiencing death has always motivated people to think about life. It is this human-existential dimension – some speak of a spiritual dimension – which is nurtured by the great questions of life and

[6] See Weiher (2011) and also Dileo and Dneaster's discussion (in Dileo 2005) about levels of music therapy in hospice and palliative care.

which cannot be developed without intensively looking at death and dying. Francois de la Rochefoucauld's maxim "Neither the sun nor death can be looked at steadily"[7] does not match the author's experiences. Accepting death and incorporating it into one's own self-interpretation enables the development and experience of temporality – this is the root of a caring attitude which neither has to achieve a therapy "goal" nor to "accomplish" anything. Looking at death and coping with it clears space for deeper and more meaningful relationships and for being amazed by the mystery of mankind and being human.

In the spirit of the palliative researcher Allan Kellehear, the caring of the dimension of spirituality (spiritual care) in music therapy means a therapeutic-palliative attitude of partaking, stable caring and an egalitarian encounter through guiding a human search for sense in life, death and loss. After all, good spiritual care has a lot to do with acceptance of and insight into the limitations of one's own individual professional practice (Kellehear in Heller & Heller 2014: 13f).

Clinical music therapy is not a "spiritual therapy", but the underlying definitions perhaps suggest "spiritual caring". Spiritual care as the foundation of a culture of caring requires people to be extracted from their role as patients. In this, the attitude of hospice is reflected, which is founded on the respect for dignity and individuality. It is not about what we do *for* others but what we do *with* them! Through this, the hospice-palliative-music therapeutic "spirituality of caring" shows the human interspace as a place of encounter and action.

When such spiritual care is the remedy against de-subjectivising and de-personalising, when spiritual care is a synonym for mindfulness, self-care, welfare, caution, guidance and affection; in other words, for humanising the system in favour of the humans within it – then in this sense, spirituality and spiritual care is not only one aspect of music therapy but it reflects the foundations of all assisting professions in a clinical context which feel obliged to these principals. To care, listen, show empathy, appreciate without an agenda are general (spiritual) competences of guidance.

One can say that spirituality should not be instrumentalised, for example, as a means to manage contingencies or to cope with painful experiences. Spirituality must not be used as a cure-for-all when other remedies have failed, or when health insurances become interested in the correlation of spirituality and health because they hope that "spiritual people" might generate less costs (Heller & Heller 2014: 39).

What is more important is agreeing to "what you can recognise as good and beneficial, not just in order to feel better but because opening up to it is helpful in itself and provides real comfort even in times of hardship" (Baier 2009b: 65). Here the self takes a central position as it can only be the patients' responsibility to come to terms with what seems important to them, what is meaningful and what carries them.

When a music therapist practises perceiving this anthropologic basic attitude, this can support the patients in the context of music therapy in expressing and giving space to this elementary human dimension of reality in which they feel seen, heard and understood, in a (non)verbal musical way.

The anthropological research of spirituality contributes to elaborating the foundations of spiritual phenomena, and in return spirituality can be seen as a particularly significant phenomenon of human existence.

[7] "Le soleil ni la mort ne se peuvent regarder en face" (cited in Heller & Heller 2014: 15).

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Article

An experiential description of the tango in interwar Greece (1922-1940) through the life narratives of elderly people in care homes

Aggeliki Koufou

ABSTRACT

The revolutionary rhythm of tango – as well as the simplicity of its dancing steps – contributed to the expansion of its popularity in Greece during the interwar period (1922-1940). The purpose of this paper is to explore the socio-cultural reasons for which tango became a popular dance in Greece during that era. More particularly, the research study had two aims: to present an experiential description of the practice of tango during the interwar period, as well as to explore the emotional experience of nostalgia, triggered by popular Greek tango-songs from the interwar period. Although the Greek tango has not been prominent in Greece as a form of music or dance expression since the 1960s, I carried out a two-year ethnographic research in two homes for the elderly in and outside Athens. By adopting an interactive musical approach followed by discussions with the home residents, I was able to gain information regarding their cultural and social relationship to tango. A total of 30 narratives were collected from the residents. Historical and literary texts (e.g. press articles of that era and music magazines featuring commentaries on the music and dance trends of that age) were used as secondary narrative voices.

KEYWORDS

tango, Greece, interwar period, care homes, music-evoked memories, nostalgia

Aggeliki Koufou studied music at the Department of Music Studies in Corfu with further accordion studies at the Richard-Strauss Conservatory in Munich. In 2011, she obtained her doctorate from the Department of Music Studies, University of Athens. Her PhD research centred on *"The culture of tango in Greece during the interwar period (1922-1940): A musicological and anthropological approach"*. Aggeliki is presently based in London where she provides music sessions to vulnerable people with Alzheimer's, helping to promote socialisation and stimulation of essential memory centres.

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INTRODUCTION

The wave of dance mania which was expressed in capital cities such as Paris, London and Rome in the 1920s (Baim 2007; Collier et al. 1997; Wiser 1983) encouraged the popularisation of dancehalls and dance academies where the upper and middle classes went in order to learn how to dance the tango. Nevertheless, in Greece, tango was not heard and danced only in dancing schools or luxury dancehalls but also at feasts or in taverns, where ordinary people would sing with guitars, accordions and violins. Tango was for Greek people a favourite means of entertainment; however, this paper also involves examining the Greek tango as a medium for seeking communication and companionship.

This article consists of three parts. First, the theoretical background that includes a) an outline of the general socio-historical and cultural framework of Greece during the Greek interwar period, b) ethnography as a method of examining tango as a form of cultural expression, and c) a discussion of the theoretical aspects within the emotional context of 'nostalgia'.

The second part comprises the methodology section which describes how the data was collected and analysed as well as the challenges that I faced in my research. It presents the empirical material from the care homes and addresses a number of limitations of the research.

The third and final part of the paper gives a brief description of the results and looks at previous research in the field of ethnomusicology. Finally, it includes some considerations for future research for the wider music and health field.

THEORETICAL BACKGROUND

Historical context

The Greek interwar began in 1922, four years later than in the rest of Europe, for a number of reasons. This period was characterised by intense political, economic and social instability in Greece and is connected with the establishment of two dictatorships, with the appearance of women in the labour force and the rapid urbanisation of Greek society, which was guided by an ideal of Europeanisation. Thus, the urban masses which developed in Athens and other cities of Greece, wanted to reshape the musical life of their country by resorting to European music, which they expected would remove any Byzantine elements and folk songs which connected them with the sad past of four hundred years of Turkish occupation[1].

The interwar years in Greece were also marked by an intense interest in dance. This period was attributed by the press as being an invaluable form of entertainment for a large part of contemporary Greek society. Within this cultural context, the tango found its peak as a form of expression through dance and Greece, in particular, bore witness to a 'Golden Age' of tango during the 1930s.

An introduction to ethnography as a method

Considering that tango is a form of both musical and dance expression which some might say no longer bears any resemblance to current aesthetics or social needs, the empirical aspects of the tango culture in Greece were approached via ethnographic research, using residential care homes situated within both urban and rural environments.

The ethnographic field research, the daily and long-term presence of the researcher with a cultural group of people while aiming at understanding and recording their lifestyle, is a distinctive feature of anthropological research (Marcus & Fischer 1986: 18). Through fieldwork, anthropology was fed new material on the basis of which new theoretical and methodological choices were developed. Since the 1920s and until recently, ethnographic field research with participatory observation remains a basic method of anthropological analysis that includes the following key features (Gefou-Madianou 1999): a) it enables the ethnographer to observe and interpret experiences and opinions that would otherwise remain unknown, and b) it is a method to 'discover' new theoretical tools which were not known in advance but emerged through participant observation.

A key issue associated with the anthropological method of field research is that a large part of the research process is guided by the theoretical interest of the researcher in a fixed phenomenon or problem. Therefore, we could conclude that ethnographic fieldwork is a method that is unique and subjective, as the results of the description of the examined musical-cultural phenomenon vary according to the sector from which the scientist hails, the questions submitted, and the theoretical framework that has been shaped by the aforementioned scientist.

Nostalgia and memory

Popular tango-songs of the interwar period which the elderly were able to recognise and sing, triggered various emotions of which nostalgia was most frequent. Nostalgia has been characterised as a complex and "bittersweet" feeling (Janata et al. 2010; Van den Tol & Richie 2014), as it may cause a mixture of sadness and joy, insecurity and desire. Often, but not necessarily, nostalgia is accompanied by autobiographical memories (Janata, Tomic & Rakowski 2007; Janata et al. 2010; Van den Tol & Ritchie 2014) and an emotional response is often caused by listening to

[1] From 1453 until 1830 when Greece gained its independence from the Ottomans, the Greeks had little contact with Western music and were familiar only with Byzantine hymns and Greek folk songs.

famous songs. Hearing songs from the past can therefore trigger mixed feelings and memories of a certain time period and/or a person, event or location.

Exploring the narratives of the elderly based on the theory of nostalgia seeks to highlight two things: a) ideas, attitudes, memories, events and reviews related to the practice of tango during the interwar period, and b) nostalgia as an emotional experience for the mental and physical wellbeing and quality of life for the elderly.

The theoretical approach of 'nostalgia' has been important in this research, as it takes into consideration the comprehension and interpretation of the ways elderly people manage the passing of time emotionally, especially as they may spend the last years of their life in an institution from which – at least in most instances – there is no way to return to the family environment.

As a concept, the word 'nostalgia'[2] implies loss and refers to a world of yesterday that serves, as far as the subject is concerned, as a "safety valve" (Tannock 1995: 456). This way of approaching the past transfers the subject from an unstable present to a stable past, thus expressing the belief that back then, the function of life and human relationships were better. Benveniste and Paradellis, in their article *'Memory and historiography',* in investigating the processes of memorising and the complex issues that arise regarding the role of memory in society and intellectual life, write the following about nostalgia:

> "The past we represent or (re)construct is always more coherent than what actually happened. Our nostalgia celebrates a clarity that fights the chaos and the uncertainty of our days" (Benveniste & Paradellis 1999: 23).[3]

Nostalgia can be interpreted sometimes as a negative, and other times as a positive emotion. As a negative emotion, it causes a person to feel melancholia and sadness, upon realising that the past is definitely lost. It is often connected with emotions such as, for example, misery, rage, desperation, hatred and shame. It is also examined as something pathological, likely caused by brain damage, as a flight from reality, as a denial of time or denial of history's effects on the present (Boym 2007; Tannock 1995; Thompson 2000).

As a positive emotion, nostalgia can help a person redefine his/her identity and review issues that give rise to concern. In his article entitled *'Nostalgia critiques'*, Tannock (1995) notes that nostalgia is a legitimate way for constructing and approaching not only the past, but the future as well, since it can bring significant social changes to a person's private and social life. Based on this view, nostalgia can help a person in the following ways: first, to reinforce their self-esteem so as to adjust more easily to the rapid changes happening in society and their interpersonal relationships; and second, to reinvigorate human bonds by connecting yesterday with today. Through participating in activities reinforcing socialisation, nostalgia can also strengthen the belief of sensitive social groups that they too are a factor contributing to the development of societies. How nostalgia is approached determines how significant it is in matters examining the past and memory. One of its basic aspects, as was mentioned before, is that the negative experiences of life are usually filtered and the past is recalled in a manner that is better than what really was the case in the first place.

Investigating the relationship between memory and emotion is a complex enough matter that transcends the aims of this study.[4] However, based on the theory that "memory is not merely a passive storage space for past events, but it changes and redirects itself from the needs of the present" (Kyriakidou-Nestoros 1988: 235), it was evidenced in this study that the idealisation of yesterday's mode of entertainment was done from the standpoint of the present era. This way, the past was considered to be "honest" and "romantic", in contrast with the current "vulgar time, where young people only dance having sex on their minds". All of the elderly persons involved in the study concluded that the beauty of the time they lived in was a result of "purity" and "kindness" instilled by the society of their own time (Koufou 2011: 265).

Moreover, the theoretical approach to nostalgia created further concerns surrounding the complicated relationship between memory and emotion, which emerged only after the end of this research. As noted by Schulkind, Hennis and Rubin

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[2] Seremetaki (1997:35-37) clarifies that the Greek term *νοσταλγία* is "vastly different than the notion of romantic sentimentalism" indicated by the English term nostalgia. In Greek, the verb *νοσταλγώ* is a composite of *νοστώ* and *αλγώ*, and it signifies pain, longing or yearning to return to one's homeland.

[3] All direct quotes from Greek literature have been freely translated here.

[4] The importance of memory for oral history is undoubtedly of great significance. It is in the author's interest, in future research, to strengthen the present methodology through a dialogue involving oral history and cultural memory.

(1999) in their article entitled *'Music, emotion, and autobiographical memory: They're playing your song'*, the feeling of nostalgia may also express the pleasure felt by the residents in their efforts to remember incidents and persons from their distant past. Therefore, it is difficult to clarify "whether the emotion elicited the memory, or the memory elicited the emotion" (Schulkind, Hennis & Rubin 1999: 953).

Voices of the elderly persons: The "bittersweet" emotional experience of music-evoked nostalgia

One female resident, having connected nostalgia with dancing and youth, recognised the positive effect of dancing as a way of managing reality:

> "I remember the period of tango with nostalgia. Although it was a hard time, when you're young and healthy and there's a spark in you, things come to you differently, you're stronger when you face hardships."

The following narratives underscore the differences in the modes of entertainment and the behaviour differences between the old and young generations. This highlights, according to the elderly, the superiority of the past and the positive interpretations of nostalgia:

> "Now they dance and kiss and all that. Back then no one was allowed to do that, it was all done in secret."

> "Yes, yes. It was romantic back then, relationships were more pure."

> "Back then, we'd have fun in a brotherly manner, now these things don't exist anymore […] now, everything's done in order to get some."

> "Today, there's alienation. There's no fun […] people don't have fun in their homes."

Nostalgia for dancing among the elderly was stronger when a bereaved person would become entangled in their narrative. For some, realising the loss of that person from their lives meant either distancing themselves from dance and/or music, or developing feelings of insecurity about the present. The following narratives of elderly persons show some negative ways of approaching nostalgia:

> "Oh yes, yes. It was nice. Romantic. Everything's there, but what good are they? […] I long for my companion above everything else […] we lost everything."

> "Memories have faded, they're all gone. It only gets you so far […] what we do now is the problem."

> "Dancing was all we had […] now, these years have gone. We got nothing. No dancing, not our loved one. It's best not to remember these things."

The past was used by several elderly persons in order to stress that "in their time…", meaning the time when they danced and sang, and they were young. Therefore, for them, tango represented the carelessness of their youth, and it was also connected with personal experiences that sometimes had a pleasant ending, although sometimes they did not. Nostalgia for their own past lives increased through symbolisms and meanings accompanying the practice of tango; these also had effects on their later lives:

> "When I went out dancing, I had a fling with a musician. He then came to me and asked me to dance. He was a young man, tall and thin. He lived in Pagrati, and his father was a wing commander. I mean, he came from a rich family. All the time we were dancing tango, he talked to me. This was how we met. I wore a black dress with a white collar, my golden cross, and flat shoes. My hair was long and brown-blondish. Then I fell sick, and he came to my house to see me and meet my parents. When I got better, I visited his house on the last night of the Carnival season, there was going to be a dance there, too. There, he introduced me to his father as his fiancé, but his father threatened him that if he continued seeing me, he would disown him. He owned, you see, two apartment buildings. After that, we broke up for a while, until the war, and then we completely drifted apart."

> "My boyfriend and I met at a party. It was really nice […] I had fallen in love with him by talking to him during tango, and I wanted for us to tie the knot."

By emphasising their emotional relationship with music and dancing, the elderly attempted to recreate, in their opinion, ideal human relationships. Friendly gatherings in houses, careless fun either in dance schools or in neighbourhood dancehalls, assumed the form of images; images imprinted on their memory, remembering the "kindness" of people and the "moral" (or not) behaviour during dancing. For others, the uninterrupted link they had built throughout their lives with dance and music was interpreted as a sign of life, and it became manifest with the idea of organising dance events such as galas inside the care home.

Claiming that the sorrows of life are more than its joys, they narrated that dancing was not only a significant part of their past life, but of their present life as well, since it helped them deal with old age with optimism. Contrary to stereotypical views that old age is a process of retreating from life from both social and cultural environments (Thompson, Itzin & Abendstern 1991), many of the elderly persons interpreted their situation as a challenge, due to the fact that they needed, more than ever, to respond decisively to the organic and psychological changes they were experiencing. As a result, those who considered the past as residing in the present, attempted to render the emotion of nostalgia in the bodily movement of dance.

METHODOLOGY

Data collection and analysis methods

The field research that began in February 2008 and concluded in the autumn of 2009 was centred on two care homes, in Athens and Nafplio. These two institutions were selected to establish a picture of tango practice in the interwar years in Greece, and involved the playing of popular songs of that era on my accordion. There were five visits in 'Athens',[5] each lasting approximately an hour and a half. The Athens home consisted of five 'wings', where elderly residents were housed according to their age, mental, physical and financial conditions. In 'Nafplio' four visits were made, each of them having the same duration as in 'Athens'.[6] The age of residents ranged from 72 to 94 years old, and they were all mobile except for one elderly woman who used a cane.

Although the idea of field research in care homes seemed to be quite interesting at first, my beliefs about old age were, to paraphrase Proust, "more vague than any other form of reality" (Beauvoir 1973: 12). The elderly represented the 'Other' to me. My visits taught me to realise that my definition of old age came from me, the observer, and it was grounded upon stereotypes I had embraced, involuntarily or not, regarding the experience of old age. The time I spent with the elderly residents proved to be of great value to me. I finally adopted the view suggested by Thompson, Itzin and Abendstern in the book '*I Don't Feel Old: The Experience of Later Life'* (1991) in which they state that the age during which the biological decay of an individual commences is also dependent on that individual's overall stance against the challenges of life.

My proposal to entertain elderly persons with dance music from the interwar period was met with enthusiastic approval from the social workers in charge of each care home, who also participated themselves in the research. It is thanks to their interest that I had the opportunity to converse with remarkable and sensitive people, which enabled me to capture their memories about tango and the overall music and dance atmosphere of the interwar era.

Our musical meetings were held in large rooms where the elderly people eagerly waited for the music sessions to begin. They would usually get their daily meals in these rooms; at other times of the day the rooms were used for musical entertainment or other activities along with coffee. In the first instance I noticed – both in Athens and in Nafplio – that men chose to sit together on one side of the room and women on the other side. Sitting in a semicircle with me in the middle, however, I could gain visual contact with everyone.

The tango-songs used as a methodological tool in this investigation were selected using two criteria: a) the popularity generated by the press and music magazines of that era; and b) the narratives of known Greek composers, singers and lyricists who have dealt with tango in the interwar and/or post-war years.

Having prepared about forty dance songs from the interwar period, my aim was to encourage participation through singing and/or dancing, to evoke memories around the music and dance movements of a time gone by – those of the years of their youth. In their time, they said, they "experienced happiness, a bliss that will never come back, ever". They "had fun in a way that doesn't exist anymore, you won't see it anywhere", they "respected moral values ignored by the youngsters of today". In their time, "people fell in love through dancing". Singing and dancing, as some of them pointed out, "was their entire life".

Other than the entertainment value, discussions with the elderly revolved around topics such as:

a) Their relationship with music – whether they learned to play a musical instrument or not, their familial environment with music.

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[5] From this point onwards, I will refer to the homes in Athens and Nafplio using the terms 'Athens' and 'Nafplio' respectively.

[6] Other than my planned visits to Athens, I also took part in several excursions during the summer of 2009 as a musician.

b) Musicians and singers – their impressions of Greek and/or foreign musicians they had listened to.

c) Their relationship with dancing – which dances they preferred, whether they had taken dance lessons or not and where they took such lessons (at a dance school or at home), the reasons why they liked tango.

d) Their views about our time – how they evaluate their era and its entertainment as compared to that of today's young persons.

e) Matters of behaviour at dance schools – whether specific codes of behaviour existed.

The discussions that followed the music, due to illnesses and/or psychological states, were sometimes done at group level and at other times individually.

The presence and active participation of the care staff in this musical activity was particularly important for the following reasons: for their help in filming the reactions of the elderly to the songs they heard;[7] to ensure the physical integrity of the elderly; and mainly, for the continuous emotional support and encouragement they provided regarding the importance of interactive music. Thus, their active involvement in live vocal music enabled the care staff to acknowledge the benefits of an interactive musical approach. It was noted that certain familiar songs could tell the story of an individual or of a particular period in their lives while others brought to mind meaningful people, places and/or strong emotions. The songs also promoted verbal expression (e.g. individuals who didn't speak very much discovered not only that they could sing, but they could also recall lyrics accurately and confidently) and non-verbal reactions (some elderly would nod their heads and tap their feet to the music or they would just sit with their eyes closed rocking back and forth). Gradually, a shortlist of songs which the elderly demonstrated as being very important and/or meaningful was collected. These songs were sung at the same tempo as they were originally recorded and were played on the accordion. Each song was played twice with all verses, so that everyone could have the opportunity to listen, to remember and to participate.

> "You know this song *'The Last Tango'*? Well, let me sing it for you, my girl, maybe it'll come back to you."

In Nafplio as well as in Athens, it was interesting to observe the bodily reactions as, on several occasions, the elderly would get up to dance without any assistance and would form either same-sex or heterosexual dancing couples. The elderly people with better physical health were pleased to be given the opportunity to remember the four basic steps of the European tango. From our very first meeting, in both care homes, those who preferred to sing while dancing immediately stood out. Although there were some elderly persons who did not dance at all, the camera recorded their calm, smiling faces and their humming. One female resident claimed she did not dance out of embarrassment; despite the fact that she knew all the songs by heart and she admired those who danced, she refrained from dancing because of her age.

> "My age doesn't allow me to carry on like that. It's a shame, my girl, for me to dance with all those years on my back!"

Throughout the visits I made to Athens and Nafplio, I noticed that women were more willing to dance than men, sometimes with help from the care staff, other times on their own, making short turns around themselves or along the room and also raising their arms. One female resident, in particular, was so excited with the prospect of dancing that, after our first meeting, she would show up dressed for the occasion, with lightly painted lips and wearing black low-cut patent leather shoes, her "dancing shoes", as she would point out. It was observed that when elderly persons danced more, either with each other or with the help of the care staff, their bodily movements augmented their mood for verbal communication. In Nafplio, especially, several residents who knew each other from before often completed each other's narrations, thus encouraging other residents to join in.

On one occasion I visited with two colleagues, a pianist and a professional singer, in order to see if there were different emotional and/or bodily reactions. For that particular event, many new songs were included in the repertoire. It is interesting to note that the elderly people became enamoured by the professional singer. As a result, communication between the elderly was enhanced and significant memories which could conceivably have got lost were recovered.

The elderly responded with great enthusiasm to the idea of talking about their music and dance experiences. Melodies of songs and tangos such as, for example, *'Cruel heart (Skliri kardia)'* (1935), *'Withered are the violas and violets (Maramena ta*

[7] All visits were videotaped with the help of the care staff.

yulia kai oi violes)' (1935), *'To love and not be loved (Na agapas kai na min agapiesai)'* (1936), *'The fishing boat tango (To tango tis psaropoulas)'* (1940), were songs that most residents believed could express their own lives and emotions.[8]

The willingness of the elderly to talk about their music and dance experiences was mostly influenced by two factors: a) the selection of songs which acted as a beacon to awaken memories and emotions; and b) the familiar and friendly relationships that were built up over time. One female resident, for example, wanted to give me advice on the "dangers and evils" of life every time we met and before saying goodbye. She also expressed a desire for me to devote some time to her, in order to discuss privately my life in Athens, my family, my ambitions, my dreams. Over time, saying goodbye became more and more emotional:

> "When will you come back, my girl?"
>
> "Should we wait for you tomorrow?"
>
> "That was fun! You'll come again, won't you? Don't forget us"

A familiar environment was slowly established, one where songs and dance acquired a special emotional value, both for the elderly and for myself. Known melodies played with the rhythm of tango and other popular songs from that era, such as waltzes and foxtrots, allowed the elderly to use music as a "memory bank" (Chatwin 1987: 108) in order to awaken themselves, reconnect with their past, and remember with their bodies.

The field research in care homes went smoothly with respect to communication, yet I sometimes faced difficulties at an emotional level, since the effort to remember past experiences would 'awaken' feelings of sadness, fear, insecurity and/or social alienation within some of the elderly. In such instances, a touch, a gesture, a smile, a cheerful talk proved to be my most valuable and irresistible allies. However, I made the decision to cut short my research in Nafplio after the fourth visit, due to an unforeseen event – the death of a female resident, who was the 'soul' of Nafplio. She was the first to start singing and the last to stop dancing. Her loss had a significant effect on the psychology of the other residents, to the extent that their mood for singing and dancing was greatly diminished. On that day, the elderly man with whom she usually danced asked me:

> "And who am I going to dance with now, Aggeliki?"

The awkwardness I felt at that time meant I could not find the proper words to soothe the sorrow of that man. The emotions he felt affected him so much that he withdrew to his room for a very long time.[9] A social worker suggested at what was to become the final session that my work was somehow pointless, since she felt that the music could no longer preserve the equilibrium of the elderly.

Methodological limitations and future considerations

In the two years I spent visiting the elderly, I sought to create a pleasant environment through singing as well as a socio-cultural context of communication. However, as the approach and understanding of a musical phenomenon based on a particular theory, "not only shapes the research process but also determines its problems" (Gefou-Madianou 1999: 252), I often wondered about a) the recording and analysis of their narratives, b) points of their narratives that may have not been interpreted sufficiently, and c) if the questions submitted unconsciously guided their answers. Even if a part of the research process was influenced and guided by a certain theoretical interest, I found that by sharing memories and expressing emotions through music, the elderly people themselves shaped the survey research design, problems and its conclusions.

The results from the ethnographic research in both care homes have revealed the importance, according to this author, of identifying how the elderly praise their life experiences with tango. Just as Myerhoff, in her book '*Number Our Days',* (1980) depicts the way of life for several Jewish elderly people in Los Angeles, in order to underscore the importance of the narrative experience, elderly nostalgic narratives in this ethnographic research are not being shown to reconstruct history, showcase the accuracy of events or the objective "ethnographic truth" (Clifford & Markus 1986: 7; Merriam 1964: 49) about beliefs and mindsets of that era or, the music and dance

[8] Discussions with the elderly would usually last one hour, and the musical part would last for approximately 30 minutes. However, based on their moods, the entertainment part would occasionally be longer or shorter.

[9] Even after I completed my visits to both care homes, I continued to be in contact with the social workers so that I could be informed about the residents' wellbeing.

memories of the elderly, but to point out the subjective experiences and, most importantly the mental state associated with the recollection of memories. In addition, using nostalgia as a catalyst to evoke memories and emotions (positive and/or negative), the interest of this study focused on whether the elderly were able to escape from the inevitable comparison between past and present, therefore drawing the sense of nostalgia and mental strength for the future.

Some methodological limitations of this research identified are as follows: as the ethnographic research was limited to only two care homes, future research would include conducting participant observation in care homes in other cities of Greece, which will bring to the surface more information on the historical and social transformations of tango. Moreover, the collection of a larger sample of this social group and the design of a sample survey with a questionnaire (thereby using a quantitative research approach) that will be available, for example, in different care centres around Greece, will lead to more data in order to draw broad conclusions regarding the examined musical phenomenon.

Another limitation of this study relates to the selection of tango-songs used in the care homes. Although most of the elderly people were familiar with the songs, they were not chosen by them. Related research undertaken around the relationship between music, emotions and autobiographical memories (Van den Tol & Ritchie 2014), has indicated that self-selected music rather than experimenter-selected music, may cause intense emotional reactions and more detailed autobiographical memories. However, this study did not examine whether the song-hearing exclusively selected by the elderly could be associated with specific individuals and/or events of the past.

It is also argued that popular songs which raise strong emotions are recalled in memory better than songs which trigger mild feelings (Schulkind, Hennis & Rubin 1999). This research, while considering the relationship between music and the emotional profile of nostalgia by listening to popular songs from the years of their youth, could not prove that the elderly were able to remember all the lyrics of the tango-songs, their titles or the names of the singers. Furthermore, songs that they liked more than others strengthened their will to remember some lyrics, without necessarily engaging memories around the practice of tango. It would be interesting, therefore, for future research to explore whether the frequent repetition of a single turn of popular tango-songs would lead to different results in the degree of recollection of events, people and ideas and in relation to the historical, social and cultural context of this musical and dance expression.

FINDINGS

Research in Athens and Nafplio proved that tango was danced in the interwar years in many places around Greece (Xanthi, Thessaloniki, Volos, Leucada, Ithaca, Patras, Athens, Nafplio, Mani, Syros, Skopelos and Crete), and that it was also danced by Greeks from Egypt and Constantinople. Based on their place of origin and their own histories, the music they requested consisted mainly of traditional folklore or popular songs, as well as some classical and light music.[10] Those who had a European music education were explicit in their renouncement of bouzouki,[11] claiming they preferred light music. Others said that they listened to zeimbekiko,[12] traditional and light songs with equal pleasure. Several female elderly persons originating from Caesarea, Egypt and Constantinople had grown up dancing karsilama[13] and European dances, but they also said that they wanted to learn more dances.

This wave of dance mania in the interwar years, as became evident from the narratives of the elderly, engulfed not only urban centres, but also the rural areas. An article in the newspaper *Elefthero Vima*, dated 1923, comments on the intense dance activity of the era: “And they all dance, regardless of age and profession […] artists, seamstresses, office, bank and ministry typists”. Still, the dance mania of the time was not always praised by the press.[14] The first negative critique in Greece about the close contact of bodies in the tango was written as early as 1914 in the

[10] The term “Greek light song” refers to a particular kind of song that rose to prominence in Greece during the 30-year period from 1930 to 1960, with the creative support of many Greek artists. Light songs, both with regard to their melody and their arrangements, are based on Western standards and their lyrics are mostly about love.

[11] The bouzouki, the guitar and also the baglamas, are the main instruments used in rebetiko. Rebetiko is a genre of Greek music played in Greek tavernas.

[12] Zeimbekiko is a Greek folk dance.

[13] Karsilama is a Turkish couple dance that is also known in Greece under the name Antikrystos.

[14] *Elefthero Vima*, 29.06.1923 and 20.12.1924.

newspaper *Proodos.*[15] Six years later, the newspaper *Kathimerini* protested about the lack of public concerns given the reality faced by the country, remarking the need for people to “stop thinking only with their feet and put their logic into action, if only so they could succeed in tidying up the mess they are in”.[16]

“Singing and dancing was our entire life”, “Dancing was in my blood”, “We used to dance almost every day”, “Youngsters back then wouldn’t meddle with politics, they preferred to dance instead”, “Dancing was all we had”, “It was a crazy period, yes, yes […] we were crazy for dancing”.[17] These – and other similar phrases – were how the 30 elderly persons described their relationship with dancing. Motivated by their memories, they reached back into their childhood/teenage years and recalled how their parents would sing light songs from the era and play traditional and European melodies on the clarinet or the violin. There was only one resident from a village outside Nafplio who said that he would go only occasionally to summer festivals and fairs. Although he himself didn’t dance, since “his heart didn’t seek festivals” as he put it, he still did listen to some European music.

Four out of 30 residents interviewed lived in rural areas and were employed in agriculture. Their isolation and low income contributed to their lack of a high level of education and/or exposure to Western European culture. The majority (24 out of 30) of the elderly residents came from cities with stable employment and education opportunities. They included retail workers, teachers and craftsmen, who sought to learn a musical instrument as well as traditional Greek and European dances. Their economic status also enabled them to attend musical and dance events which took place in Athens or Thessaloniki. Eminent artists of the interwar era included names such as Attik, Gounaris, Giannidis and Bianco. The remaining four residents who had the required finances (a captain, a professional pianist, a professional dance teacher and musician and a professional dancer), could also afford a personal gramophone and records. Often, they would organize dances in their homes, thus contributing to the dissemination of Greek Westernised music (dominated by the tango).

Furthermore, for these four elderly persons music and dancing were their chosen professions. Their narratives are of great interest for two reasons: firstly, because we can clearly see how their social and educational levels greatly facilitated their professional involvement with music and dance; and secondly, because their choice of profession also reflected the beliefs and mindsets of the Greek interwar society in relation to artistic careers.

A male resident (a former captain) narrated how he had begun his music career as an amateur drum player in the community band of Nafplio, and he subsequently became a bandmaster. He knew how to dance traditional and European dances of which he stated preference for the tango. A woman narrated that she had taken lessons in piano and European dances from a dance teacher in Crete, and she subsequently taught piano and dancing. At the same time, she expanded her knowledge of music by learning the mandolin and the violin. In the Athens sessions, I had the opportunity of having a lengthy discussion with a man who had been a professional piano player and had collaborated with some famous Greek composers, namely Theodorakis, Chatzidakis and Oikonomidis. He had studied classical piano at the Music School of Volos, but soon turned to jazz music, playing in luxury hotels and cruise ships. He narrated that his professional relationship with music was the reason for his broken marriage, since his father-in-law treated him with contempt as a “*musicante*”, a second-rate musician. He nevertheless managed to work abroad as a musician, ensuring a good pension for his old age. With respect to dancing, he claimed that he knew plenty of Latin and European dances “inside out”. He stated that his father was one of the first dance instructors in Volos having studied European dances and tap dancing in Paris in the 1920s. Finally, there was a female resident who had participated in shows in Delfoi and Epidavros as a professional dancer. However, she narrated that she had to stop due to intense disputes with her mother concerning moral dilemmas related to that profession. Subsequently, she changed careers to teaching English.

Although some elderly persons claimed that “all dances are nice” such as, for example, waltzes or foxtrots, and that “each dance has its own grace”, most of them talked about the superiority of the

[15] More specifically, the newspaper *Proodos* accused Zappeion National Girls’ School for teaching the immoral dance of tango. *Mousiki*, issue 25, 1914.

[16] *Kathimerini*, 15.03.1920.

[17] In 1936 in particular, an article of the magazine *To Tragoudi* comments on the fact that dancing was the most important mode of entertainment of Athenians, and that, furthermore, there were not enough dancehalls to satisfy the desires of dance enthusiasts. *To Tragoudi*, No. 24, 11.1936.

tango. For the elderly women, more specifically, tango was the dance of love, of romance or of the aristocratic class. Men, for their part, emphasised the sensationalism of tango and the pleasure they felt embracing a female body. With or without close physical contact, tango was the "best", the "ideal" dance for two reasons: first, because it would calm them from listening to "annoying and loud jazz music";[18] and second, because it combined sensual music and simplicity of steps with bodily and verbal communication. The phrase "don't you prefer if we discuss it while dancing" was firmly connected with the practice of tango, and for many residents who were active participants in the dance movement of that era, words, glimpses and gestures while dancing were all a "part of the program".[19] Almost all residents were able to recall positive impressions left by the orchestras of the era,[20] some of which would diversify their programmes by adding traditional and European songs:

> "Oh my, yes! Songs were all mixed up. Bouzouki and violins and clarinets. After zeimbekiko, we would turn to 'hugging' (tango)."

Already from the 1920s, tango in Greece was danced in dance schools or 'Dance Academies', as they were otherwise called. By the end of the 1950s these had seen significant levels of attendance. The profession of dance teacher was regarded as an ideal occupation during the interwar period; in 1926, the press commented on the constant rise in the number of dance schools.[21] Dance teachers regarded their profession as a sort of civil service, winning the favour and appreciation of middle and high social classes. Dance schools weren't necessarily places that anyone could frequent, since in several places in Greece they were a place of gathering for sophisticated people, with a certain social and financial standing. A female resident who originated from Crete narrated the following:

> "Villagers wouldn't go to dance schools. It was a place for fine people, wealthy people! It was no place for tramps. The door would shut and you would dance in peace. You wouldn't be harassed, and they wouldn't talk to you, tell you dirty stuff."

Nevertheless, tango dancing in Greece was not merely a subject of dance schools; it also took place in houses, where friends and relatives would get together so they could sing and dance. In fact, many residents thought this type of entertainment to be quite common, due to the fact that on the one hand, dance schools were expensive and on the other hand, they didn't think that they would have a better time by visiting a dance school or a dancehall. As such, there were many who had learned European dances the old-fashioned way, which was by going from house to house. A resident originating from Crete provided a narrative about how someone could learn how to dance the tango in rural areas:

> "We had fairs in village squares or houses, and so we got to learn the dances […] the best nights were in houses. I know this one, this one's better, he knows this thing […] these were great nights. We sang, we danced and we learned. There was communication, and this was something that stayed with us later on in life […]."

The choice of the 'old-fashioned' way also allowed parents to observe, from head to toe, the manners and the moral standards of male guests. As such, dancing was frequently a pretence so that a mother could deduce who the best husband would be for her daughter, a motherly method, which in most cases would be met with disagreement from the daughter.[22] Several elderly women who had similar experiences did not hesitate to express their annoyance about the pressure exercised on them to settle down through marriage. Moreover, they narrated that dancing was not always a pleasant activity, due to the fact that girls would often quarrel as to who would get to dance first and with whom. Some were forced to dance with each other; as one resident commented, "what were we supposed to do, just sit there and look at each other?"

There were a few residents who learned to dance not in a dance school or at a house in the company of friends, but in a schoolyard or village square. One resident from Nafplio narrated that when she was about ten years old, there was a young schoolteacher who taught traditional and European dances to all classes of her school. This is why she thought she didn't need to go to a dance school to improve her technique. Yet later on, when

[18] *Mousiki Zoi*, Year Two, Issue 1, October 1931.

[19] *Elefthero Vima*, 15.07.1923, 22.02.1931, 2.03.1938.

[20] The first Argentinean orchestra with Eduardo Bianco as a conductor came to Greece on 3.11.1929 and was considered to be the biggest musical event that ever took place in Athens. Bianco's appearances in theaters and famous dancehalls of that era were essential in increasing the popularity of tango in Greece. Cinema and the radio also played an important role in this respect.

[21] *Elefthero Vima*, 9.02.1926.

[22] *Elefthero Vima*, 9.02.1926.

she was married and went to dance school her husband would often make displays of jealousy. Still, according to residents from both care homes, such displays of jealousy were something women would also do. A wife or a fiancée, by discreetly observing her husband's dance behaviour, could sense whether this was just a dance or something more. One female resident narrated the following: "I didn't care for either men or women. I just did my thing, dancing and flirting".

Several elderly women claimed that it was "embarrassing" for a girl to deny a dance to an unknown boy, while others chose to say the 'big yes' or the 'big no' on the basis of a boy's external appearance:

> "If I didn't like the way he looked, or I didn't like him in general, I wouldn't get up […] I'd tell them that my feet hurt. If someone I liked came close to me, then my pain would suddenly go away."

Other elderly women, those originating from Ithaca and Constantinople, narrated that whenever they would go dancing, they didn't feel "free" to dance with young men they didn't know, since all attendees' eyes would turn to them in an instant. For this reason, they preferred not to make new acquaintances on the dance floor, but rather in the neighbourhood pastry shop, in order to avoid comments that were likely to place either themselves, or their parents, in an unfavourable position. A resident narrated the following:

> "Boys would sit at one table and girls at another table, all together […] when my boyfriend wanted to say hello, he would pretend that he was straightening his hair […] you see, things weren't free back then, and a lot of things would go on in secret. Parents, those poor people, didn't ask to learn but trusted their children, and didn't want to embarrass them on dates."

By contrast, most elderly men claimed that it was their intention to dance with many and different girls: "I didn't have a specific partner, because I was searching for the right one", a resident said. When it came to prohibited contacts between the bodies of dancers, many elderly men said that the more they liked their date and the words they would exchange with her over dancing, the more they would "press" their bodies to theirs.

CONCLUSIONS

This article addressed some of the findings from my doctoral research, in particular highlighting the integration of a culture of tango within both urban and rural Greek communities, a topic for which there are no extant publications within the Greek language. Two theatrological studies (Hatzipantazis & Maraka 1977; Siragakis 2009), an ethnomusicological research (Kitsios 2006), an academic work for tango (Lazana 1997) and an ethnographic research by Cowan (1990) in a northern Greek town, stood as valuable guides to explore the culture of tango in Greece. Greek literature on tango is typically based on music magazines of that era, historical texts on music, and (auto)biographies of famous Greek artists who have engaged with this form of music. Thus, because the presence of the social/historical transformations of tango in Greece is a topic over which there have not been many writings in Greek, its study led to a new combined approach based on the fields of musicology and, in particular, ethnomusicology, history and cultural anthropology. The aim of this ethnographic research as a methodological approach, was to consider tango as a form of cultural expression, thus revealing the function of popular music as a major source for the study of social relations over time.

It may be true that tango, as a music and dance expression, has completed its life cycle in Greece; however, it became apparent through these narratives by the interviewees, that dancing, music and singing were useful factors for understanding the way Greek society in the interwar period perceived love, companionship, social presence and criticism, and overall the ideological management of everyday life. As such, we could say that the ethnographic research on the subject of tango culture presented here is a study of change and motion, since music and dancing were used as tools to represent the evolution of social relationships over time.

Moreover, I would like to consider the contribution of this research regarding the study of old age as a cultural phenomenon. Based on the emotional effects of tango-songs, the elderly reconstructed a past which even if not represented on the basis of social or historical reality, served social needs. From this viewpoint, the tango, as a genre of popular music, acted as a vehicle for enabling the elderly to express their feelings, to feel socially connected and to strengthen their confidence. It is therefore important, in this author's opinion, to note the fact that these narratives do not merely describe or evaluate the music and dance atmosphere of their time. They neither refute nor identify primary sources. They do include, however, experiences, thoughts, emotions, body memories, and also silences. Together, all these constitute the

identity of elderly persons and bestow meaning to their lives, thus offering alternative narratives about the past.

Musical reminiscence, as Thompson (2000) stated, can greatly improve the verbal and physical communication of elderly persons and can therefore be a catalyst of change in the atmosphere inside the care homes or the medical institutions where they reside. Although such recollections cannot treat neurodegenerative diseases such as Dementia and Alzheimer's, music, songs and other audio-visual stimuli can contribute positively to the change of behaviour and psychological status of elderly persons. In his book *'The Voice of the Past: Oral History'*, Thompson (2000) commented that treatment through reminiscence is not a panacea. In other words, significantly strengthening communication and dialogue among a group of elderly persons could cause withdrawal or depression, adding more tension to the already existing negative feelings. As the present research has shown that "contemplation does not fit equally everyone" (Thompson 2000: 233), the idealisation of the past by some residents and their attachment to it, could lead to the expression of negative thoughts. The research concluded that negative emotions (e.g. insecurity, anxiety, anger and sadness) expressed by some of the elderly people, necessitated the help of a professional music therapist and/or psychotherapist.

However, a factor made clear to me through my relationships with the elderly was that their words, on most occasions, do not have much bearing on their actions. This means that even when they get frustrated about their age, their past or present, or the depleted state of their body, what they yearn for is to have their voices, their memories, their concerns and/or their fears heard. As a result, things that are otherwise very simple, such as, for example, a discussion about an experience from their past, may not only assume the form of images and emotions, but it may also have a significant influence on improving their psychological condition.

Yet, in addition, their memories highlight the crucial influences of dance and music in their everyday mode of managing their health and psychosomatic states. Whether or not there were moments from the past the elderly associated with a particular song, or they needed to reconsider, to reassess their past, to redefine their identity or to express their feelings, this study suggests that interactive musical activities which recall memory and can be converted into physical and movement mechanisms, are essential for their physical and mental wellbeing. For this reason, some easy memory questions about the songs and artists of the interwar era were incorporated into the sessions. This had positive effects on the psychological state of the elderly, demonstrated by their participation in the music and dancing activities, the expressions on their faces and even their applause. The importance of interactive music as well as music's power to soothe, to energise and to arise dormant memories are well documented in the field of music therapy (Aldridge 2000; Ansdell 1995; Carruth 1997). The research presented here suggested that an entertaining music session, combined with other kinds of stimulating cultural activities involving eye-contact, actual touch and communication, could be therapeutic for the elderly.

In conclusion, although the present study was based on a small number of participants, it hopes to offer stimuli for further studies in a systematic effort that popular music is not a unique means but a multiple reality (Brackett 2000; Middleton 1990; Shuker 2001). Therefore, as the memories of elderly persons can help considerably in observation, recording and analysis of popular music, the latter can be used as a tool of 'auxiliary memory' to withdraw significant (autobiographical) memories and emotions.

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Interview

The third edition of 'Music Therapy Research': An interview with Barbara Wheeler

Barbara Wheeler & Daphne Rickson

ABSTRACT

In this interview Professor Barbara Wheeler reflects on the development of the third edition of *Music Therapy Research* (Wheeler & Murphy 2016). Through a historical lens spanning more than two decades, she points to key and influential colleagues in the field and notes how each of the editions of the book has broadened to include a wider range of international perspectives and approaches to research. In explaining the important changes that she and her co-editor Kathleen Murphy have made in the third edition, she signposts current emergent trends and contemporary issues in the significantly changing landscape of music therapy research.

KEYWORDS

music therapy research, quantitative research, qualitative research, objectivist research, interpretivist research

Barbara L. Wheeler, PhD, MT-BC, holds the designation of Professor Emeritus from Montclair State University, where she taught from 1975-2000. She initiated the music therapy programme at the University of Louisville in 2000, retiring in 2011. She presents and teaches in the US and internationally with current faculty appointments at the University of Applied Sciences Würzburg Schweinfurt, Department of Social Studies, Würzburg, Germany; and Karol Szymanowski Academy of Music, Katowice, Poland. She has been an active clinician throughout her career and worked with a variety of clientele. Barbara edited *Music Therapy Handbook* (2015) and the three editions of *Music Therapy Research* (1995, 2005, 2016) and is co-author of the two editions of *Clinical Training Guide for the Student Music Therapist* (2005, in press). She is also the author of numerous other articles and chapters. She is a past president of the American Music Therapy Association (AMTA) and was Interview Co-editor for *Voices: A World Forum for Music Therapy*. Barbara received an Award of Merit from AMTA in 2016.

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Daphne Rickson is a senior lecturer on the Master of Music Therapy programme at Te Koki, the New Zealand School of Music, Victoria University of Wellington. She has practised music therapy with a range of populations but particularly with children and adolescents in schools. Her recent research projects have involved critical analysis of the concept of disability and investigation into music as an inclusive resource; including participatory action research with young people who have intellectual disability. She is currently investigating singing for wellbeing with teachers and children in a Christchurch school severely affected by earthquakes. She is the author of numerous journal articles, and is co-author of the 2014 book '*Creating Music Cultures in the Schools: A Perspective from Community Music Therapy*'. Daphne is an associate editor of *Approaches: An Interdisciplinary Journal of Music Therapy*.

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Daphne: Firstly, congratulations to you, Barbara, and to Associate Editor Kathy Murphy, on the publication of the third edition of *Music Therapy Research*! It's been a long journey since you published the first edition in 1995 entitled *Music Therapy Research, Quantitative and Qualitative Perspectives*. Shall we start at the beginning?

Barbara: Yes. Around 1991 Ken Bruscia, my colleague and friend, called me to suggest music therapy needed a research methodology book and that I should be the person to edit it. He has a very good perspective on what music therapy needs and that's why he's done so well with Barcelona Publishers. He knew that I could do it and also thought it would help people to place me – taking advantage of some of my skills and knowledge that people weren't aware of – to become known as someone who does "that research stuff". My PhD was in educational psychology which was really a research-focused degree so it was a good thing for me to be doing. I don't think at that time I knew anything about interpretivist (qualitative) research – it was just emerging – but I was trained well as an objectivist (quantitative)[1] researcher and he was correct that I could do it although I've learnt a huge amount along the way! And it is now the way people know me, which has been great for me in the final years of my career.

Daphne: What did this opportunity mean to you as a practitioner?

Barbara: I've always believed that research is important for music therapy practitioners. One of my main reasons for getting the Degree in Educational Psychology was that I wanted to be able to contribute to music therapy research which I felt, way back in the early 1980s, was not very relevant to what clinicians did. A lot of the research was with people who had 'mental retardation' as it was then called, and looked at their responses to reinforcement such as the amount of eye contact they might give… and it had very little to do with what I saw clinicians doing or what I did as a clinician. And so from very early times, I've had a feeling that research should apply more to clinical work than it does. One of my early objectivist studies – which was not a good study! – was looking at various interventions that music therapists did in psychiatric work and trying to see the effects of the different interventions. Looking back it was very naive to think we could even begin to figure that out in that way but I was trying because that was relevant to what clinicians were doing!

When I left the University of Louisville in 2011 – when I thought I was actually retiring – I decided not to do any more clinical work. And that's probably the only thing I actually did stop at that point! But in general, as a clinician, I'm aware of the research and the importance of the research for informing what we do as clinicians. I spent some time recently with Lori Gooding from Florida State University and I was so impressed that with everything she talked about she would add "and the data show this…" and "the data show that…" and "therefore we did it this way". I don't rely on the data in that way but I really admire that. I am a firm believer that we have to do things that are grounded in what we know from research. And I would like to emphasise that that is not always objectivist research! I'm sure you're familiar with Brian Abrams' (2010) article in the *Journal of Music Therapy* in which he talks about Wilber's 'Four Quadrants' and how music therapy practice *and* research are viewed differently in these four quadrants. I think that's a brilliant article.

Daphne: Things have certainly changed a lot since the first edition was published!

Barbara: Yes, in many ways. When we were putting together the first edition of *Music Therapy Research* that was published in 1995, I was aware the whole time that it was almost a miracle that the book was going to happen because we were asking people to write about things they hadn't written about and trying to pull so many things together. That information had not been 'put out there' in music therapy. We were really pulling things together and only used US authors. The reviewers from the United Kingdom correctly commented that this was too bad that it only had US authors yet I remember thinking at the time that it never could have happened any differently, it was so difficult to bring the material together that first time. The text included a section on qualitative research with two chapters by Kenneth Aigen, one of which was an overview, and another which was titled 'Interpretational Research' and covered several types of qualitative research that involved interpretation; as well as four chapters by Ken Bruscia. The first of those was about 'Topics, Phenomena, and Purposes in Qualitative

[1] 'Objectivist' is used in the third edition of *Music Therapy Research* to refer to what is generally known as quantitative research, and 'interpretivist' is used to refer to what is generally known as qualitative research. These terms are used to indicate a broadening of the understanding of ways of classifying research.

Research', and the other three described various stages in the process of doing qualitative research. And there was a chapter on phenomenological research that Michele Forinash wrote. Those chapters were important. But I don't want to forget other people were writing about research also, perhaps not quite at the same time but shortly afterwards – Henk Smeijsters, David Aldridge, Gary Ansdell and Mercédès Pavlicevic – all published books on research. And those added to our music therapy literature on research and research methodology.

Daphne: And so the second edition in 2005 incorporated more international perspectives?

Barbara: By 2005 we were absolutely ready for a more international group of authors! The second edition of *Music Therapy Research* not only reflected the fact that we *had* the first edition and could build from that but also at that point we had a much more international research community that was communicating. There were obvious people outside of the US to invite contributions from, like Brynjulf Stige – I couldn't imagine not asking him to write the two chapters that he wrote (participatory action research, and ethnographic research). There are many other people from outside of the US included in that second edition – Dorit Amir, Henk Smeijsters, Trygve Aasgaard, Denise Grocke, Eckhard Weymann, Rosemarie Tüpker – those are just the ones from outside of the US who wrote chapters on designs, of course there were many wonderful people from the US also and people from outside of the US who wrote chapters in other sections of the book.

International perspectives are important because across countries, research – even what we think of as 'research' – is quite diverse. People will describe their research to me sometimes and it's fascinating but I can't even understand how they think they're finding out what they think they're finding out! I'm not saying they're wrong but they have a very different way of thinking than I do. I've presented in most parts of the world at this point and I always make it clear that what we do clinically is not research. We really need to make some distinctions between what we do clinically, what we do in terms of good observation, and what we do when it's actually research. I'm not sure where the line is (sometimes it seems clearer than at other times), but I don't think it's all the same!

And there are broad differences in the way people approach research too. In New Zealand, for example, your participatory, collaborative, action research has been really important[2]. Your work, and the work you have done with Katrina McFerran from Australia, has influenced what others see as legitimate research. In the US there's a big emphasis now on randomised controlled trials (RCTs), and on many interpretivist kinds of research, particularly phenomenological. I think there are trends in various countries, probably based on two things: partly on what people do clinically but partly on what some of the influential researchers have done. I point to you, for example. The research you have done, the action research[3], has really made a difference in how people think about not only research but how they think about the areas that you research.

Daphne: In what other ways was the second edition different to the first?

Barbara: I would like to think that some of the changes had to do with what people were able to figure out from the first edition. As well as the international contributions there was huge expansion in the qualitative sections. Twelve chapters were included in the second edition, compared to three that were actually on designs in the first edition. And I think those chapters helped to define more of what we do! Prior to that, and unfortunately still a little bit, people would say "I'm doing a qualitative study". But it's not enough to say that. For years we've suggested you need to say what interpretivist methodology you are using and in saying that you're obliged to learn more about that methodology and explain more of what you are doing. And some things can be hard to define or describe! As an editor I had to work with the authors to make sure that their chapters were clearly differentiated. We tried in the second, and now in the third edition Kathy Murphy and I worked to have a lot of research examples. When you consult an actual research study as an example you really have to examine whether it meets the criteria for whatever design you're looking at. And that's where you get into "it doesn't quite use this design… but it's still an example…" or "it's this type of design, but it really looks more like that (other) design…". But I hope in each edition we get more and more refined in how we look at these things.

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[2] See Rickson et al. (2014) and Rickson and McFerran Skewes (2014).

[3] See Rickson (2012).

Daphne: And as we are refining our methodologies, the music therapy field is expanding!

Barbara: So the third edition of *Music Therapy Research* has many more chapters. There have been huge increases in both the 'objectivist' and 'interpretivist' sections (which in previous editions were called 'quantitative' and 'qualitative' respectively). We decided on these terms for a number of reasons. They are terms that are used in the broader literature (e.g. O'Callaghan 2009; Schwandt 1994) – we just didn't come up with them on our own – and we thought that they made some of the bigger issues clearer. It's easy to think that you can talk about objectivist and interpretivist (methodologies) and that they're starkly different – one uses numbers and the other doesn't. But it's so much more complex than that. And so after much discussion those are the terms we decided to use. I think it is consistent with other writing although I'm not suggesting in general around the research world that people are going to start talking about objectivist and interpretivist research. But I hope that music therapists will find the changes useful while still being able to talk with others about 'quantitative' and 'qualitative' methodologies. And so the book has a lot of changes including information on many new designs.

Daphne: What led to the decision to have a co-editor for the third edition?

Barbara: Ken Bruscia chose not to be as involved in the third edition as he had been in the first two. And when I realised he was not going to help me in the same way as he had with the previous books (where he had an enormous impact), I didn't think I could do it alone! Kathy was my choice. She's a fabulous researcher and scholar who really wants to get to the heart of things. We work well together and we like each other. So we worked together on everything although we had different roles. Although I have overall responsibility as editor, in many cases we split duties, with one of us writing and the other one looking at it. In some cases we did the same thing but with different chapters. It was a very, very nice process working with her. She shares responsibility for the good things as well as the problems of the book I think, because we did this together!

But Ken still had a large role particularly at the beginning in the planning stages, then again near the end. Towards the end of the process we decided to have an introductory book, which is just a portion of the big book. It largely leaves out all the design chapters. Ken wrote three chapters for the introductory book – one each of 'objectivist', 'interpretivist', and 'other' methods. In working through all that, in an effort to ensure it made sense, we reorganised the book. The microanalysis chapter for example has been divided – there is now one on objectivist microanalysis and one on interpretive microanalysis. But they're in a third section of the book called 'other' designs that includes designs that did not fit easily into the objectivist and interpretivist sections. So a number of things changed because they made sense organisationally.

Daphne: What advice would you have for music therapy researchers moving forward?

Barbara: One of the most important things for contemporary music therapy researchers moving forward is the need for continued quality. We see in the objectivist Cochrane Reviews that much of the music therapy research that they find is judged to be of "not good enough quality", to have "high possibility of bias" and so on. And this has helped our research because many more people are now aware that we just can't do some of these little designs that just don't work very well. If we're doing RCTs let's make the RCTs really decent! One of the chapters in the book that I ended up spending a lot of time on was the 'Crossover Design' chapter. And one of the things we learnt when doing that chapter with Darcy DeLoach was that most of the music therapy designs don't use a 'washout' period as is required for that design. If there is no washout period between the time you do one treatment and the time when you cross it over to another control, you can't tell if there are real results or just carryover effects. So a lot of our research that uses crossover designs really doesn't work according to the standard. Also, many RCTs have not used true random assignment to groups. So I think that continued improvement of quality is really important.

For interpretivist research I think we need to be surer about our designs, so if we go to another design – a mixed methods research study of any kind, whether it's interpretivist or objectivist – we need to be really clear of what we were doing initially, and then what we are changing to. I sometimes call it 'mixed up methods' when I see people aren't clear! They just kind of go back and forth. Ken Bruscia has talked for decades about the need for epistemological clarity in what we do and that's also emphasised in the book. Interpretivist

research needs to be better and better in terms of using the designs well and getting the most you can out of it. We've included in the book a bunch of interpretivist designs that have not been done much in music therapy – some of the critical approaches which involve analysis of text for example. I realised music therapists have concentrated on phenomenology and grounded theory because that helps us find out what we are interested in. But there are whole areas of research – feminist research, for example (included in this book as part of the interpretivist section, in the chapter titled 'Critical Inquiries: Feminist Perspectives and Transformative Research') – which is really important, and other disciplines have used them. I'm hopeful that this book will prod people to do research in some of those other areas also.

Daphne: A final word?

Barbara: I've done objectivist and interpretivist research using a few different designs in each of those areas, including a bit of historical research. I like to think my main contribution is in helping other people to learn and think about research. Obviously I couldn't talk and write about research if I didn't have some experience in doing research myself but I think my contribution has been to help people to understand and think about it, and I continue to do this as I write and present.

Daphne: Thank you, Barbara, and congratulations again on this super contribution to the music therapy profession – a resource that will have an important influence on music therapy research, and practice.

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APPROACHES

Report

Twenty years of music therapy at Berklee College of Music

Suzanne Hanser

ABSTRACT

This report is an account of the establishment and progress of the Music Therapy Department and Institute at Berklee College of Music in Boston, Massachusetts, USA. It is a retrospective look at 20 years of faculty/curriculum development, special initiatives, events, and trends in the education and training of music therapists. It offers some insights into the factors that guide programmatic focus and change.

KEYWORDS

programme development, music therapy, curriculum, history of music therapy

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A SHORT HISTORY

This report is a personal reflection on 20 years of music therapy at Berklee College of Music in Boston, Massachusetts, USA. It highlights the contributions of a diverse faculty whose expertise built instructional designs for training future generations of music therapists. It lists the initiatives that have served as springboards to investigate trends in the music therapy profession and to construct a vision for training leaders in new directions. It approaches the challenges of innovation in a rapidly changing healthcare and education environment. Currently, 156 music therapy majors are enrolled as undergraduate students seeking board certification as music therapists in the United States, and an initial cohort of 12 students is currently working towards the Master of Arts in Music Therapy. The vision of the Music Therapy Department has been to prepare prospective music therapists to apply multiple genres of classical and contemporary music to their work in traditional and innovative clinical applications, while understanding the underlying mechanisms and outcomes of music therapy.

Photograph 1: Dean Darla Hanley, Chair Suzanne Hanser and faculty celebrate 20th year

© Approaches

THE START OF MUSIC THERAPY AT BERKLEE

I will never forget the telephone call that I received from the President of Berklee College of Music, Lee Berk, in 1993. President Berk was committed to fulfilling the college's mission to offer a multitude of careers in music, and contacted me as President of the National Association of Music Therapy to discuss the possibility of adding music therapy to Berklee's impressive list of music professions. President Berk appreciated the promise of offering students a way to use their talents in the service of others. His keen business sense and philanthropic nature predicted that the combination of a fine music college specialising in contemporary music, improvisational methods, international approaches, and the latest music technologies, located in a city with prestigious educational and research institutions, amongst neighbourhoods of renowned medical and healthcare settings, could form the perfect confluence of conditions for a state-of-the-art programme.

I told President Berk that I would identify a qualified consultant to conduct a feasibility study on the potential of creating a music therapy programme at Berklee, never thinking that, two years later, I would be asked to become the founding chair of that department. In 1995, I arrived in Boston to develop all the necessary ingredients to establish a curriculum designed to train music therapists for the 21st Century. Now, 21 years later, I still serve as chair, and the department boasts nine additional faculty, two staff positions, and a new graduate programme for the practising music therapist who is interested in leading the profession in innovative new directions and supporting a research agenda in music therapy.

BUILDING A HOUSE FOR MUSIC THERAPY

Building a programme is like building a house in that it is necessary to have a set of plans, a foundation, an architect, and master builders who are experts in their trades.

The foundational principles that guided this effort included a number of assumptions about a high quality music therapy education:

It is based on the evidence amassed about music therapy interventions and their outcomes

In *Possibilities and Problems for Evidence-Based Practice*, Edwards (2005) extols the importance of applying strategies that have been documented to affect behaviour in specific, therapeutic ways. It was my first mission to amass those music therapy protocols from various philosophies and practices around the world and hire experts to teach these techniques.

It must expose students to the various approaches and philosophies that music therapists apply to their work

Wigram, Nygaard Pedersen and Bonde (2002) include a wide variety of music therapy approaches in the comprehensive guide to the field. It was important to include as many theoretical and practical models as possible in the Berklee curriculum, while ensuring that the validity of one approach would not negate another. It was essential to encourage students to embrace an openness to different ways of looking at music therapy, and to hire experts in various approaches. In a chapter that I contributed to the *Oxford Handbook of Music Therapy* (Hanser 2016), several aspects of curricular development were highlighted: healthcare and education trends, technology, levels of practice, the need for personal therapy, and multicultural issues. These are just a few aspects of education and training that are currently under scrutiny, and must be accounted for in any sound music therapy curriculum.

It is culturally competent, and involves experiences with diverse populations that represent our global society

In today's international network, it is possible to have access to theories, techniques and research from around the world. International organisations, such as the World Federation of Music Therapy (WFMT) and the International Association for Music and Medicine (IAMM) offer communications from multiple continents and provide resources that are accessible to all. Given that most clinicians will be working with people from diverse cultures and ethnicities, curricula must reflect this diversity.

It is taught by experts who have clinical experience as well as theoretical knowledge

A department is not simply an office, just as a curriculum is not just a collection of course syllabi. At Berklee, our department is now an entire team of master builders and experts, and our curriculum is given life by vibrant and competent faculty who bring their distinctive perspectives to training future music therapists. Berklee was fortunate to attract a diversity of faculty in musical specialty, theoretical approach, and clinical experience, contributing to

the breadth and depth of the curriculum. The faculty is composed of experienced music therapists who are also educators and leaders.[1]

It includes closely supervised clinical experiences concurrent with training (practica) and post-training (internship)

Clinical practice alongside classroom learning has long been a value held dear. Back in 1978, when I was revising the music therapy curriculum at University of the Pacific, I wrote a manual to guide student experiences in clinical practica (Hanser 1976, revised 1980), and published this "systems analysis approach" in the *Journal of Music Therapy* (Hanser 1978). Later, Chad Furman and I (Hanser & Furman 1980) published a set of guidelines for providing feedback to students on their clinical work. Berklee's course of study includes five pre-internship clinical practica in diverse settings: special education, older adults, research (currently in community settings for the homeless, and with well elders), mental health settings, and medical centres.

It involves engaging students actively in musical experiences of many genres and types

Berklee's mission is:

> "to educate, train, and develop students to excel in music as a career. Developing the musicianship of all our students is the foundation of our curriculum. We believe that the lessons and qualities derived from that work—the self-discipline needed for excellence, the empathy required of music making and the openness and curiosity essential to creativity—are critical to achievement in any pursuit, musical or otherwise. We also believe that music is a powerful catalyst for the kind of personal growth central to any collegiate experience" (https://www.berklee.edu/about/mission-and-philosophy).

We have held our curriculum true to this value.

It consists of courses, mentorships, clinical supervision, and opportunities for service learning and community engagement.

In Boston, we are fortunate to have partnerships with some of the finest institutions in which our students practise the techniques they are learning in the classroom. We insist on close supervision with qualified music therapists in each setting.

Beyond Boston, music therapy faculty and students embark on service learning trips to other parts of the world, to engage musicians, healthcare providers, and specialists in building collaborative and sustainable programmes to meet their needs. Berklee's goal is to educate agencies and communities, through their personnel and constituents, in music therapy strategies that may supplement and enhance their existing programmes.

It incorporates the latest technologies, and prepares students to create their own innovations, particularly those that afford greater access to music and music therapy services

Berklee benefitted greatly from the presence of Wendy Magee as a Visiting Scholar, as she prepared her landmark text, *Music Technology in Therapeutic and Health Settings* (Magee 2013). Committed to developing and applying the latest music technologies, Berklee supports initiatives to meet our goal of enabling every person, regardless of ability or disability, to access music and music therapy techniques (see Music Therapy Technologies, under Special Initiatives).

It integrates a forward-moving agenda, based on predictions of market needs and a vision for the future of education and healthcare

I have heard from some architects that they fear the moment when their vision fails to align with their blueprints, and the measurements they have carefully calculated do not add up to the precise sum of the parts. This is the moment when they must reconsider their designs, discarding various elements and at times, rethinking the whole project. They report that this dreaded instant, more often than not, ultimately brings the new perspective that creates a much better home, in the end.

To build a music therapy department entails many steps forward and back, starts and stops, and boulders that impede progress along the way. I have thought about the challenges that those sorts of setbacks provided during that first year of curricular development, but also discovered the clarity that can appear when plans require a shift in thinking. So, when administrators of clinical facilities failed to return my calls or answer my queries, I identified staff members who I had

[1] The following faculty and staff members are the real authors of this 20-year retrospective: Donna Chadwick, Peggy Codding, Kathleen Howland, Brian Jantz, Kimberly Khare, Chigook Kim, Michael Moniz, Karen Wacks and Julie Buras Zigo.

reason to believe might be supportive. I offered to provide in-service trainings to social work teams and psychosocial development groups. I spoke at support groups and parent assemblies. I led music-facilitated stress management groups for staff meetings, and worked with offices of human resources to provide music therapy for staff.

I joined boards of directors in order to learn more about community needs and agendas. I presented grand rounds at hospitals, and volunteered at a number of clinical facilities. When asked to participate in interviews and newsletter entries, I offered a creative perspective on mental health, wellness, and special education. Every opportunity to perform or speak was taken. My priority was to educate the community about the impact of music therapy and the many benefits of providing music therapy services, while they educated me about the needs of the Boston community. It is these partnerships that have sustained, empowered and continued to support the growth and development of the Music Therapy Department at Berklee.

EXPANDING INTO GRADUATE EDUCATION

Berklee welcomed its first cohort of graduate students in 2015. In developing this specialised curriculum in research and conventional/integrative medicine, a needs analysis was performed to determine emerging directions in health sciences and education. Alumni were queried regarding their interests in graduate education and their values regarding those components that were missing in their undergraduate curricula and skills/credentials that might further their careers and professional trajectory. Establishing networks with healthcare service providers around the world helped to direct the course of study and identify educational resources. To meet the needs of music therapists around the world, it was determined that an online platform would be necessary for the bulk of the training. Of course, it was an expert faculty that actually conducted the preliminary research, wrote the new courses, and created the foundation for this advanced work.

The graduate curriculum leading towards the MA in Music Therapy provides advanced instruction to guide and prepare music therapists for today's global and community-based approaches to healthcare and education. These music therapists focus on neuroscience, research, clinical music, technology, music cognition, global perspectives, and the latest advances within the field. With specialty tracks in integrative medicine and research, students contribute to a contemporary approach to music therapy, as they strengthen their skills and allow their practices and research interests to evolve. We believe that students not only enhance their professional skills and knowledge through such advanced study, but that they will also grow as leaders of the music therapy profession.

LEADERSHIP OF THE COLLEGE

With the support and guidance of the administration of Berklee College of Music, the Music Therapy Department has been able to forge a vision for the future of our profession. As Dean of the Professional Education Division at Berklee, Darla Hanley has been a champion for the highest standards of education. As Dean of Assessment and Graduate Studies, Camille Colatosti has ensured that our graduate curriculum employs expert consultation and the latest technologies to provide the finest advanced training to practising music therapists. Provost Larry Simpson has provided access for our department to engage professionals throughout the college community to support our goals. President Roger Brown has valued our vision as part of the mission of Berklee. Their leadership has facilitated multiple initiatives that have taken root and grown over two decades.

Many offices of the college provide other resources. For example, Berklee Press has published *The New Music Therapist's Handbook* (Hanser 1987) and *Manage Your Stress and Pain through Music* (Hanser & Mandel 2010). Berklee's Valencia campus invited Kathleen Howland to present a TEDx talk on *How Music can Heal our Brain and Heart*. Special programmes, like the Performance Wellness and Global Jazz Institutes at Berklee have also reached out for expertise and support from music therapy faculty.

MUSIC THERAPY INSTITUTE

The mission of the Music Therapy Institute (MTI) is to advance the cause of music therapy on a regional, national, and global level and to fully establish music therapy as a recognised viable treatment option. MTI exists to:

- establish innovative models for music therapy service delivery, training and research, which may be replicated nationally and internationally.
- support a strategic goal of the American Music Therapy Association (AMTA) to promote and provide scientific data that demonstrate the effectiveness and outcomes of quality music therapy services.

- raise public awareness of and support for music therapy services.
- increase music therapy services in established and new clinical sites in the metropolitan Boston area.

This mission is met through a variety of activities including:

- creating and expanding replicable model music therapy programmes at highly acclaimed sites, such as Dana Farber Cancer Institute, McLean Hospital and Children's Hospital of Boston.
- providing key music therapy services to underserved populations while simultaneously increasing the number of available qualified music therapists, including safety net, and inner city health and educational services. This occurs at Boston Medical Center, a local women's shelter known as Rosie's Place, and other settings.
- conducting controlled research trials that document the effects of music therapy, such as at Boston Medical Center, in collaboration with the Department of Integrative Medicine and Health Disparities (Roseen et al. in process).
- publishing the outcomes of research studies and 'best-practice manuals' for replication of successful clinical protocols e.g., supporting preparation of articles in *Journal of Music Therapy* (Hanser et al. 2011).
- training clinical supervisors to teach student music therapists the skills they require to become competent professionals.
- supporting special projects, such as: music therapy services at Franciscan Children's Hospital and Tufts Medical Center Floating Hospital for Children, funded through a CVS Caremark Foundation Grant; and *Music InSight: Assistive Music Technology for the Blind Musician*, funded through major grants from the Grousbeck and Hilton Foundations.

MTI currently contracts with over 60 partner organisations to provide clinical training and research opportunities for music therapy students. It connects Berklee College of Music to healthcare, education and arts organisations that serve the therapeutic needs of Boston communities, and provides resources to organisations aiding in the establishment of music therapy programmes. Other educational opportunities are offered through symposia, training institutes and research initiatives.

SPECIAL INITIATIVES[2]

It has been important to consult our community of colleagues, including researchers, clinicians and educators in music therapy and in inter-professional disciplines, in order to select the particular initiatives for departmental focus. Each year, we have identified specific themes to complement music therapy training and development. In certain cases, symposia have led to new curricular offerings, such as with music therapy technologies. The desire to meet the needs of blind musicians at Berklee led to the hiring of Chigook Kim, an assistive music technology curriculum, a symposium, and new research proposals. In all cases, events have been well-attended, and led to new directions in approaching familiar or innovative topics. We have always combined music performance with presentations of subject matter, clinical demonstrations where relevant, and case material, when possible. We have experimented with various formats. For example, in the *Music & Science Symposium*, we provided iPads for participants to tweet their questions to speakers, which were projected onto the stage of the Berklee Performance Center. We have arranged for many of our presentations to be live-streamed so that interested parties who live far from Boston, Massachusetts, could participate. We have attempted to look within Berklee for in-house expertise, our local community for talent and wisdom in specialties related to music therapy, and across the nation and globe for leadership. When it was not possible to engage these players in Boston, we used videoconferencing and telecommunications to connect them to our audiences. Having a team of creative problem-solvers and forward-moving thinkers has, perhaps, contributed most to the success of these initiatives.

Autism speaks and sings

Conferences to educate professionals and families in the applications of music therapy for individuals on the autism spectrum.

[2] Additional information about the initiatives mentioned here can be found on Berklee's website: https://www.berklee.edu

Photograph 2: Poster for Perspectives on Music Therapy and Autism

Music and science

Symposium to integrate expertise in music, science, technology, cognition, neurology, and music therapy, and create bridges to the greater community.

Photograph 3: Poster for Music & Science: Practice & Convergence

Assistive music technology for the visually-impaired musician

- Curricula to empower visually-impaired students to gain skills required of every musician.
- Establishment of an assistive music technology laboratory.
- Sound Vision Symposium on music and the visually impaired.

Photograph 4: Poster for Sound Vision: A Symposium on Music and the Visually Impaired

Boston arts consortium for health (BACH)

A consortium of community agencies in greater Boston that involve music and other arts in health and healing.

Global music therapy

Symposia, curriculum and guidance to support student-led service learning trips around the world, including Panama, Colombia, Uganda, Kenya, Ghana, Puerto Rico and India.

Photograph 5: Poster for Global Music Therapy Symposium

Music therapy technologies

- Partnership with MIT Media Lab and Music Therapy Department to work with residents of Tewksbury State Hospital as they learn music composition apps.
- Partnership between Electronic Design/ Production and Music Therapy Departments at Berklee.
- Development of New Music Therapy Technologies and Training Symposia.
- Music Therapy Hackathon.
- Music and Health Apps: Course offered jointly by Berklee College of Music and MIT.

Photograph 6: Poster for The Future of Music Therapy: Training in Music Therapy Technologies

Music therapy and neurology

- Training in Neurologic Music Therapy offered at Berklee.
- [TEDx talk by Kathleen Howland]
- Partnership with Spaulding Rehabilitation Network.

Photograph 7: Poster for international Training Institute in Neurologic Music Therapy

Music therapy and wellness

- Development of curriculum, including *Mind-Body Disciplines for the Musician.*
- Student-facilitated groups specialising in *Healthy Rhythms*, *Kinesthetic Flow*, *Circle Singing*, *Facilitating Drum Circles*, and *Drummassage.*
- Collaboration with Berklee's *Performance Wellness Institute*.
- Events as part of Music Therapy and Wellness Week: Flourishing through Music.

Photograph 8: Poster for Music Therapy and Wellness: Flourishing with Music

Music therapy and pain

- Memorandum of Understanding to support collaboration with Tufts University School of Medicine and its Pain Research, Education and Policy (PREP) programme.
- Collaborative clinical trials to determine impact of music therapy at Dana-Farber Cancer Institute and Boston Medical Center (Hanser et al. 2006; Roseen et al. in process).

Research initiatives

- Music Therapy for Women with Metastatic Breast Cancer at Dana-Farber Cancer Institute.
- Music Therapy for Individuals with Dementia and Their Family Caregivers.
- Music Therapy, Massage Therapy, and Usual Care in the Family Medicine Unit of Boston Medical Center.

INGREDIENTS FOR SUCCESS

Over the past 20 years, our department has been fortunate to partner with experts and agencies in diverse fields to build music therapy services, research, educational programmes, events and symposia, while learning from colleagues in multiple disciplines. A vision for the future of music therapy has only been possible with the following elements:

- highly qualified faculty within music therapy and related disciplines.
- students who are accomplished musicians from around the world.
- administration of the college who share values and offer the guidance and support necessary to succeed.
- partnerships with community agencies who value music therapy as an evidence-based practice.
- research collaborations with experts from multiple disciplines in respected healthcare and educational institutions.

I have been in the fortunate position to surround myself with talented, creative, visionary, and competent people who have enabled music therapy at Berklee College of Music to thrive and evolve. The future holds even more opportunities to build new models for music therapy that will serve the profession and the world.

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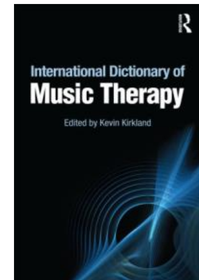
APPROACHES

Book review

The International Dictionary of Music Therapy (Kevin Kirkland, Ed.)



Reviewed by Helen Short

Title: The International Dictionary of Music Therapy | **Editor:** Kevin Kirkland | **Publication year:** 2013 | **Publisher:** Routledge Publishers | **Pages:** 186 | **ISBN:** 978-0415809412

Helen Short, MA, has a broad experience of working with children and adults diagnosed with mental health and behavioural difficulties in inpatient and community settings. She practises in London and Cambridge (UK) with West London Mental Health NHS Trust, Cambridge and Peterborough Foundation Trust and Chroma Therapies. She presented her clinical work at the European Music Therapy Congress in 2013 and the World Music Therapy Congress in 2014, and her work has been published in several music therapy journals. She is guest lecturer at the Guildhall School of Music and Drama in London.

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Upon discovering the *International Dictionary of Music Therapy* I was intrigued as to what exactly the publication would comprise of and had questions about the purpose and content of a dictionary dedicated solely to our profession. This is the first music therapy dictionary, with Kirkland taking his inspiration from Routledge's *Dictionary of Art Therapy* (Wood 2011) and outlining his intention to publish a work that serves to connect music therapists across continental lines and establish more of a global common music therapy language (Kirkland 2011). Having made links, collaborated and shared ideas with colleagues practising internationally this made sense to me.

The array of contributors is certainly interesting. Kirkland makes clear in the preface the intention he had of creating a rich source of culturally diverse contributors from other countries, contexts and "far-away places" (p. xxvii). Canadian in origin, he assembled entries from 89 authors based in Australia, France, Latvia, Russia and Scotland, to name a few. What is also made clear is Kirkland's stance respecting the knowledge of both the expert and the novice, with entries from some of the most experienced and internationally renowned researchers and clinicians: Jos de Backer, Felicity Baker, Barbara Wheeler, sitting alongside those from students in the field such as Melissa Telford, a trainee in her fourth year of study of the Bachelor of Music Therapy degree. This allows the presentation of views of the most trusted voices in our profession alongside new and upcoming practitioners shaping our ever-developing field.

Although the majority are music therapists, there are a handful of contributors specialising in other fields including music education, musicology, medicine and psychology, and the material covered is broad. Kirkland describes his audience as "music therapists, theorists, educators, researchers and students" and states the focus of the material is upon "terms, models, founders and methods that can typically be applied to a range of client needs" (pp. xxvii-xxviii). This covers many areas including research, clinical practice, philosophy, sociology,

science and the technical aspects of music. I was interested to read entries on the brain stem (Stephen Glascoe and Liz Coombes, p. 16) and brainwave states (Lee Bartel, p. 17), areas I have not yet needed to consider in my clinical work, and it was useful to refresh my knowledge on the intricacies of modulation (Peter Martens and Kevin Kirkland, pp. 76-77). Of those more specific to the profession, entries defining familiar facets of music therapy or terms we might encounter or apply on a daily basis, such as Jin Hyun Kim's contribution on 'empathy' (p. 41) or Laurel Young's entry defining 'music psychotherapy' (p. 82) are juxtaposed with entries that may be more foreign to the reader such as Cecilia Jourt Pineau's entry on the 'U-Base music therapy method' (p. 135) or Kevin Kirkland's entry on the 'creation axis' (p. 30). There is also some documentation of the history of the profession via biographical entries on a selection of those pivotal to its development, such as: Juliette Alvin (Kevin Kirkland, pp. 7-8), Leslie Bunt (Kevin Kirkland, pp. 18-19) and Clive Robbins (Jennifer Lin, p. 115).

Within the music therapy-specific material the diversity and flexibility of the profession is well-represented. The way in which music therapy has adopted and utilised concepts from other professions and areas is illustrated within this book; Varvara Pasiali's entry on constructivism, a philosophical concept (p. 28), is one example of this. Again, in his writing of the publication, Kirkland describes discovering terms that he considered "unique" (p. xxvii) within a culture and there is a lovely sense of embracing the novel, emerging and unknown embodied in this publication. I was very pleased to encounter Susan Hadley's definitions of hip hop (pp. 58-59) and rap as therapy (p. 109), especially since apart from her publication in 2011, there is still a relative paucity of literature in this area. I was fascinated to read about the model of gay affirmative therapy (GAT) (Bill Ahessy, p. 51) and Gabriel Fedrico's entry on focal music therapy in obstetrics (p. 48) took me by surprise. I was led to wonder at times, however, if this was at the expense of including more widely used terms applicable to more widespread frontline clinical work. There are no entries on dementia, psychosis, adult mental health or the term forensic for example, which seemed peculiar since one would expect such definitions to be relevant globally and therefore be addressed, especially given that the publication is also directed towards students.

There are many ways in which this book can be useful beyond providing a definition. The broad selection of material provides a picture of the diversity of music therapy culture and practice globally, something which I felt was lacking from the academic and discourse within my own training in the UK. Many music therapists, regardless of nationality or context, will find themselves looking to expand their practice or, at the very least, refresh their knowledge and this book is a great starting point for doing so. Reading up on core clinical terms fundamental to therapy work could provide a helpful reminder of what it is that's so valuable about our profession and other entries could prove beneficial in stimulating reflection, or expanding thinking about clinical work. As I practise as a predominantly psychodynamic music therapist, Hadley's entry on feminist music therapy (p. 47) helped me to reframe and reconsider my work with one client and Kirkland's definition of 'acoustic ecology' (p. 1) provided some insight into the impact of the external environment upon my work in one institution. Definitions relevant to neurological music therapy caught my attention as although this was touched upon during my training, this is a field I know little about, and herein lies the value of this book. I imagine for many practitioners it would be useful to be able to access a wealth of concise yet comprehensive accounts as we never know when we may be required to present it in regard to a certain client, to a certain professional or within a certain institution. The book also offers some practical assistance via entries such as 'documentation' (Kevin Kirkland, pp. 36-37). One of the many beautiful things about our profession is that we are able to use music and our clinical skills to provide a flexible approach to meet the diverse needs of our client group(s) and Kirkland's publication is a great resource for stimulating ideas for interventions, musical structures and therapeutic approaches.

Notwithstanding its many merits, there are certain characteristics of the publication that I took issue with. Despite its broad selection of international contributors and Kirkland's goal of moving "beyond a solely North American lens of music therapy" (p. xxvii), from my perspective I would say the book retains a predominantly North American feel. This is perhaps inevitable given that of the 89 entries, 48 are written by contributors Canadian or North American in origin or who are practising in these areas. Consider Kirkland's entry "charting" for example, "the process of documenting client care in a medical record" (p. 22) which one

might perceive as distinctly American. Is this term accurate for readers beyond North America? Naomi Bell's entry of "circle reflections" (p. 23) in my opinion, could provide another example of this.

As a result of the diversity of contributors, there are obvious, inevitable differences in writing style and naturally, certain entries have a complex, technical feel whilst others feel more relaxed or generally descriptive. This means the reader is met with an uneven tone when reading the book from cover to cover although this is not such a significant problem given it is likely that the reader will consider entries in isolation.

Of the entries defining techniques, models and approaches, the benefits of an approach or intervention are often encapsulated. One prediction is that the music therapy reader would appreciate some entries taking a more critical stance. Consider Shushadarzhan's account of music acupuncture therapy (MAT), for example, which describes the intervention as a substitute for "traditional acupuncture" (p. 80). While this may be the case there is a lack of scientific evidence about the benefits of traditional acupuncture in the majority of conditions it is used for, therefore, one might assume MAT bears the same status. Although Kirkland admits encountering a vast number of terms, and that he found maintaining brevity a challenge, I would have also found it useful to have been pointed towards the limitations of an approach, where appropriate.

Kirkland also acknowledges that in collating entries from around the world, he began to realise that "some music therapy terms have a relatively [...] consistent usage" whilst others have "very diverse [...] even contradictory understandings" (p. xxvii), which may account for my disagreement with the definitions of some terms. I consider my approach psychodynamically-informed but flexible, and my reading of this book was through an open lens. I was disappointed, however, to read that Kirkland's entry on 'containment' (p. 29), although referencing Bion, neglected to include his original definition as well as the entry on 'splitting' (pp. 125-126). Furthermore, Kirkland, failed to acknowledge the work of Melanie Klein at all. I was also led to question whether further editing may have been required before the book went to print. I noticed within Kirkland's entry on Juliette Alvin he references the British Society for Music Therapy, which many British readers will know merged with the Association of Professional Music Therapists to become the British Association for Music Therapy over four years ago (BAMT 2015).

Despite my criticisms above, overall I would consider this a welcome addition to music therapy literature. It is hard to deny the usefulness of this publication and the proof of the pudding is certainly in the eating. During the process of reviewing this book I consulted it several times; once to assist a colleague trained in a community therapy approach by pointing her towards definitions of psychoanalytic and psychodynamic therapy; to educate myself in alternative theoretical models and search for inspiration for my own academic writing and to assist my music therapy trainee with her course work. I would say that this publication will continue to function as my first point of reference for future research, clinical and academic work and could serve the same purpose for others. As an 'international' publication, the book should be available to a wide and diverse population and as a reader, taking into account my own responses to the material, I imagine this could also serve to stimulate some interesting interdisciplinary discussion. I take my hat off to Kirkland for providing us with a rich, culturally diverse resource which in his own words provides a glimpse into the "expansive and expressive world of music therapy" (p. xxix).

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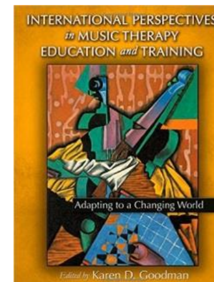
APPROACHES

Book review



International Perspectives in Music Therapy Education and Training (Karen D. Goodman, Ed.)

Reviewed by Melissa Mercadal-Brotons

Title: International Perspectives in Music Therapy Education and Training | **Editor:** Karen D. Goodman | **Year:** 2014 | **Publisher:** Charles C. Thomas | **Pages:** 343 | **ISBN:** 978-0-398-08117-1

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'International Perspectives in Music Therapy Education and Training', edited by Karen Goodman, is a comprehensive book which addresses important topics which should be part of the curricula of music therapy training programmes, such as philosophical bases on which programmes are designed, multicultural issues and the ongoing needs of the discipline to adapt to changes in society. Professional music therapists, clinicians and educators can benefit from this book's content. Music therapy clinicians will find the topics addressed in some of the chapters thought-provoking and stimulating as they are often confronted in the clinical field. For educators, the content developed in each chapter merits reflection as changes and updates are considered and implemented in music therapy training programmes.

The book is divided into three parts with a total of 13 chapters, each written by a well-known music therapy educator from countries as diverse as Brazil, Canada, Denmark, Finland, India, Ireland, Israel, Korea, Norway, the United Kingdom and the United States.

Part I: Program Design consists of three chapters, each of which centres on a training programme model and focuses on different levels of training: BA, MA, and Doctorate. Chapter 1, written by Colin Andrew Lee (Canada), a Nordoff-Robbins trained music therapist, proposes beginning with a music-centred curriculum to develop clinical musicianship, arguing that by first knowing how music works as a form of communication, it is easier to understand later how therapy works. The author defends that music is the essential element of the music therapy intervention. Musical fluency is essential for any music therapist. He proposes specific exercises to illustrate specific topics. This chapter outlines an educational process and pedagogy of music-centred education, advocated by AeMT (Aesthetic Music Therapy).

Chapter 2, by Esa Ala-Ruona (Finland), presents a multilevel training model developed by Jaakko Erkkilä, Lasse Pulli and the chapter's author, which is implemented at Jyväskylä University (Finland) and it is designed to acquire clinical as well as supervisory competencies in an intensive period of 12 weeks, depending on the

entrance level of each individual student. Within a collaborative setting, it emphasises multilevel reflective processing and includes many elements of self-experiential training.

Chapter 3, by Hanne Mette Ridder (Denmark), describes the Aalborg University doctoral programme in Denmark, which is an example of problem-based learning. The author defends the idea that it is crucial to train researchers in order for music therapy to develop as a scientific discipline. She outlines the principles of problem-based learning and explains how these are integrated in doctoral training. She also emphasises the need to promote a collaborative atmosphere and the importance of learning through peer reflections, as well as the role of the supervisor as a facilitator for self-directed and self-regulated learning with “problematization” and real world problems as key issues.

Part II: Multicultural Identity comprises the next five chapters (4-8). Chapter 4, by Robert E. Krout (USA), addresses the topic of music therapy community-based clinical learning experiences through community engagement. He describes three national and international cases which helped him develop community-based clinical experiences for his students, and how he has integrated these into the music therapy curriculum. He stresses the importance of taking into account the cultural and social context in which music therapy interventions take place at each moment in time, and presents engagement with the community as an important current issue.

Chapter 5, by Avi Gilboa (Israel), introduces the issue of multicultural thoughts and considerations, and their importance in music therapy training programmes in Israel, a country of many cultures with regard to its people and musical styles and traditions. The author introduces the *spheres* model which refers to the different domains of multicultural interaction which take place in music therapy training programmes.

Chapter 6, by Youngshin Kim from Korea, discusses music therapy developments in Northeast Asian countries (Japan, China and Korea). Since most music therapy pioneers in these countries were trained in Western countries, she stresses the importance of considering the unique cultural values, work settings and attitudes of the Northeast Asian countries when designing and revising the different levels of Asian music therapy training programmes, from initial training to supervision.

Chapter 7, by Lia Rejane Mendes Barcellos and Thelma Sydenstricker Alvares (Brazil), explains the expansion of music therapy in Brazil in the last two decades beyond clinical settings. Music therapists are currently present in many Brazilian cultural and social events with the objective of contributing to the development of identity and empowering clients through their involvement in music performances.

Chapter 8, by Sumathy Sundar (India), deals with the challenges of developing music therapy practice and training courses in India, which are at a very early stage. She emphasises the importance of balancing the country’s culture, music and healing resources with current international music therapy practice in order for the discipline to be accepted and recognised by Indian society.

Part III: The On-Going and Emerging Needs of a Discipline comprises the final five chapters. In Chapter 9, Jane Edwards (Scotland) and Simon Gilbertson (Norway) reflect, as educators, on the challenges encountered in student-teacher dynamics and learning situations during the training of professional music therapists, and how problem-solving can be approached.

In Chapter 10, Elizabeth York (USA) targets the issue of lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) and she advocates for the inclusion of this topic in the music therapy curriculum. She also provides a comprehensive list of resources for the educator.

In Chapter 11, Leslie Bunt (UK) reflects on music therapy as an artistic and scientific discipline, and how these aspects need to be balanced from the educator’s perspective, and also by the student. He also traces the development of music therapy training in the UK and explains the characteristics of each of the seven current training programmes.

Chapter 12, by Elaine Streeter (UK), focuses on the issue of supervision for professional music therapists. Based on experiences within the UK, where clinical supervision is well-established, the author stresses the importance of having a system of music therapy supervision for professionals in each country. She makes a clear distinction between the supervision of students and that of registered music therapy professionals, illustrating with examples of her own professional experience.

Chapter 13, written by the book’s editor Karen Goodman, music therapy professor at Montclair State University (USA), and widely published author, concludes the book. It tracks book publications in the field of music therapy from 1950-2014 and presents trends, patterns and needs in book publishing in the field.

This book, the first of its kind, is a very good resource for professional music therapists. It discusses the challenges of adaptation, both small and large, which affect music therapy education and training around the world in a changing and

diverse society. As interest in the profession of music therapy increases, it is crucial to enhance educational/training practices and to deepen understanding regarding cultural considerations.

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APPROACHES

Book review

Paul Nordoff: Composer & Music Therapist (Colin Andrew Lee)

Reviewed by Jacqueline Z. Robarts

Title: Paul Nordoff: Composer & Music Therapist | **Author:** Colin Andrew Lee | **Year:** 2014 | **Publisher:** Barcelona Publishers | **Pages:** 196 | **ISBN:** 978-193744064-0

Jacqueline Z. Robarts is a music therapist, specialising in child, adolescent and adult mental health. A former senior tutor and therapist at Nordoff Robbins London and head music therapist at a London NHS children's hospital, she now runs a music therapy consultancy and professional development practice (www.jacquelinezrobarts.com), offering supervision, training workshops, and improvisation lessons in the UK and internationally.

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Publication history: Submitted 26 July 2015; First published 28 August 2015.

Did you know that Nordoff was not Paul Nordoff's real name? Did you know that Nordoff wrote ballet scores for the Martha Graham Dance Company, and composed song settings of E. E. Cummings' poems? Did you know that Nordoff's life as a musician and pianist with extraordinary creative and performing gifts was dogged by struggles, financial and emotional, and lack of public recognition as a composer? Can you imagine, at the age of fifty, developing a new way of using your music to help children with special needs, and then co-writing three books, while living an international itinerant lifestyle, constantly needing to raise funds and sponsorships?

Colin Andrew Lee has written a richly documented book about the life and music of one of our best-known and most celebrated pioneers of music therapy, Paul Nordoff. It is a work of love, musicianship, dedication, inspiration, and discovery of the man, musician, music therapist. Not only essential reading for Nordoff-Robbins music therapists, but also, as Aigen writes in his Foreword: "[…] equally important for music therapists who believe in the congruence of artistic and clinical goals and who want to advance their own skills in integrating the two within their clinical work" (p. viii). It will also be of interest to musicians, musicologists and educationists, students and teachers of composition and improvisation, theatrical works, and art songs.

Lee's nine chapters chart a prismatic journey through Nordoff's life and work, focusing on his art music and his transition to music therapist, making links, one to the other, throughout: Composer (Chapter 1), Orchestral Works (Chapter 2), Piano and Chamber Music (Chapter 3), Stage Works (Chapter 4), Art Songs (Chapter 5), E. E. Cummings Songs (Chapter 6 – by Leslie De'Ath), Music Therapist (Chapter 7), From Artistic to Clinical Composer (Chapter 8), and The Final Years (Chapter 9). Copiously illustrated with extracts from the original scores of Nordoff's art music, '*Paul Nordoff: Composer and Music Therapist*' is a book to be played as well as read. (Pianists, prepare for Nordoff's enormous hand span of eleven or twelve notes!). It includes some previously unpublished photographs of Nordoff with colleagues, family and friends. Two appendices list Nordoff's composition catalogue and discography, and there is a useful index. One surprising

omission (by the publishers) is the lack of a portrait of Nordoff on the book cover: if ever a face could launch a thousand sales, Nordoff's probably could.

Through 12 years of immersing himself in collecting and evaluating Nordoff's compositions, and selecting archive material shared by close friends and colleagues of Nordoff, Lee has evidently been driven by his love of Nordoff's art music and his desire to raise awareness and appreciation of Nordoff's art songs in particular as being among the finest of the 20th century. Lee views Nordoff as "equal in stature to (Nordoff's) contemporaries Rorem, Barber, Bernstein and Copland" (p. 71). We learn that much of Nordoff's work has remained in manuscript form, with very little being performed in his lifetime. One might surmise that this experience of his music being neglected must have heightened Nordoff's empathy in later years with special needs children who, like him, were outside of the mainstream and unrecognised as having something to contribute to the world at that time. Nordoff's neo-Romantic, often jazz-influenced lyrical style was unfashionable and out of step with the contemporary musical trends of his time such as avant-garde experimentalists and serialists in the 1920s and ensuing decades. While Nordoff embraced the atonality, bi-tonality, and dissonance of modern music, Lee reveals that Nordoff always believed that his music should be accessible. He celebrates Nordoff's feeling for words and music, for natural, spontaneous human expression, movement, and spirit at the heart of his musical inspiration. To his analyses of Nordoff's music, Lee brings his own considerable skills and musical creativity as pianist, composer, and music therapist.

Photo 1: Paul Nordoff – pianist, composer, teacher, music therapist (from the cover of CD '*Paul Nordoff: Playing and singing his settings of poetry by E.E. Cummings, An Unknown Canadian Poet, & Walter de la Mare*')

In writing this review I should disclose that for nearly two decades I had the privilege of teaching the Nordoff and Robbins 'Core Studies' on the London Nordoff-Robbins Masters training programme, teaching clinical improvisation and musical resources. In studying Nordoff's therapy music in detail, with new revelations every year I came to know his work in great detail: his artistry and feeling in melodic lines, chord progressions, shapes and shells sometimes leading, sometimes following musical intent and imagination. It is therefore a delight to have the opportunity to read and play so many substantial extracts from the scores of Nordoff's pre-music-therapy music: E. E. Cummings songs, stage works, ballet scores for Martha Graham, piano and chamber music. Nordoff's range of styles – Romantic, jazz, blues – and his feeling for dance (his wife Sabine was a eurythmist), his harmonic textures and progressions, and love of the added 6th, 9th and 11th are echoed clearly, developed and simplified in his later clinical improvisations [viz. Child Studies (Nordoff & Robbins 2007) and Play Songs (Nordoff & Robbins 1968)] – which were refined or reduced versions of songs that arose out of improvisation), and musical plays, such as *'The Three Bears'*, *'Artaban'*, *'Pif Paf Poltrie'*, and *'A Message for the King'* (all Theodore Presser Co. publications). One wonders what major works Nordoff might have composed, had his music been more appreciated and performed in his lifetime, and possibly drawn him away from music therapy? In Nordoff's beautiful piano score setting of a novel by Sylvia Townsend Warner as an opera in two acts, *'The Sea Change'* (pp. 53-54), and in a one-act opera *'The Masterpiece'* (extract of the Overture, pp. 55-56), as in so many other works throughout this text, Lee has selected some of their central themes to help the reader savour the distinctive features and character of each work as a whole.

Lee's musical analyses include concise, dynamic descriptions of each work conveying the spirit, mood, texture or defining character of the piece or extract in manuscript, while making useful observations and links between Nordoff's art music and music therapy composition and improvisation. For example, in describing an extract from Nordoff's most successful stage work, *'Every Soul is a Circus'*, one of three ballet scores composed for the Martha Graham Dance Company and performed in 1939, Lee introduces it with a typically imaginative synopsis, bringing the music to life from the page, while setting it in context:

> "Later a jazz duet accompanies dancers on a see saw. Written on 12/8, the music has a lilting quality with a simple I, V chord accompaniment (strings and piano) and syncopated theme (woodwinds), balanced with a chromatic melody in sixths (flute and strings). This charming and simple movement highlights Nordoff's compositional clarity when setting music to dance. It was this sophisticated style of composing that would have such a noticeable influence on Nordoff's dance music as a music therapist with children" (p. 64).

Lee draws particular attention to Nordoff's affinity with voice, dance, poetry, and theatre. He shows how Nordoff's art works and "clinical compositions and improvisation" are not separate entities, but part of a glorious continuum of musical creativity inspired by human feeling and human stories. Leslie De'Ath's chapter (Chapter 6) on the E. E. Cummings song shows Nordoff's gift of setting words to music, capturing every nuance in ingenious harmonies, sometimes sparse, sometimes full, on the move or as poised as an arabesque. For any musician or music therapist wanting to develop their improvisation, there are myriad musical examples to explore here and discover the conversational or prosodic contours of Nordoff's melodic lines, which bring such directness, immediacy, authenticity, and emotional depth to his music therapy improvisation.

At the outset Lee suggests that in order to become a therapist, Nordoff had to let the composer in him die, that he could not be both composer and therapist. Lee's view shifts later (Chapter 7, p. 154) where he describes Nordoff's clinical improvisation and compositions for therapy as an extension (or even expansion) of his previous work and life as an art music composer. In the penultimate two chapters Lee describes the creative partnership of Nordoff and Robbins in their therapy work, teaching and writing, and in Nordoff's compositions of musical plays and play songs. The original improvised versions of many of the play songs were musically much richer and freer in harmonic texture and creative invention, arising in the moment. Some of these can be heard in recordings published in Aigen's *'Paths of Development in Nordoff-Robbins Music Therapy'* (Aigen 1998), an ideal companion text to Lee's, on Nordoff and Robbins' music therapy clinical work. Lee's final chapter, *'The Final Years'*, describes beginnings and endings in a fateful sequence of events: the first Nordoff-Robbins music therapy training course in London in 1974, the ending of Paul Nordoff's and Clive Robbins' collaboration, the last years of Nordoff's life and his return to art composition in a sombre, severe mood that reflected his state of mind. It is an extraordinarily moving experience to have this opportunity to play extracts from Nordoff's very personal final works, and to be somehow in communion with his creative spirit through his music as we are when we play and perform the great composers' works. This is due to Lee's great endeavour in bringing Nordoff's art music at last into the public domain. Surely, there will be recordings of some of these works available in the near future.

In researching and writing this work Lee has enjoyed access to many close friends and colleagues of Paul Nordoff and their archive of correspondence. From Nordoff's letters to one of his closest musician friends, Romeo Cascarino, we learn about Nordoff and Robbins' early explorations of music "as a specific therapy" and how Nordoff misses his family and children (p. 127). We learn of the sacrifices both Nordoff and Robbins made to pioneer this work and their growing realisation of how important it was. Nordoff's deepening sense of identity and purpose in his work with Clive Robbins in helping children with special needs may raise in more psychologically oriented readers' minds questions about Nordoff and his childhood prior to the age of 14 (where Lee's account begins). We are told little about Nordoff's early childhood, his parents, his inheritance from them and their past. Musically, socially, historically, it would have been interesting to know more of Nordoff's background and cultural inheritance. Nordoff's family is thought by some who studied with him to have come from Poland. For instance, could it be that Nordoff's family came to Philadelphia from Eastern Europe? Did they emigrate to the USA in the early 1900's during the Polish Revolution, part of the Russian Revolution of 1905? What hardships did they (and later their young son) have to deal with? In Nordoff's and the poet Cummings' correspondence during the 1930s and 1940s Cummings refers to Nordoff's "great depressions" comparing them with his own – touching evidence of creative artists supporting each other in their common psychological illness.

With musical sensitivity, assiduous research, deep respect and passion for his subject, Lee has shed new light on the life and music of Paul Norman Bookmeyer who became Paul Nordoff: a story of creativity and dedication, depression and despair, and the awakening of a resolve to use his music to help children who did not have a voice, could not express themselves or even have a sense of themselves, and thereby enhance their lives. In so doing Nordoff made an invaluable and lasting contribution as one of the founders of music

therapy. This is a story, beautifully told, that takes the reader to a profound place through the music of a creative genius.

> "Nordoff composed music in dialogue with life, and life often involves movement, words and story. Our lives carve out narratives. That's how we understand it" (Aigen, Foreword, p.viii).

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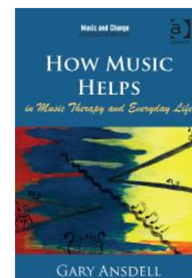
APPROACHES

Book review

How Music Helps in Music Therapy and Everyday Life (Gary Ansdell)



Reviewed by Mario Eugster

Title: How Music Helps in Music Therapy and Everyday Life | **Author:** Gary Ansdell | **Year:** 2014 | **Publisher:** Ashgate | **Pages:** 376 | **ISBN:** 978-1-4094-3415-3

Mario Eugster is a Nordoff Robbins trained music therapist. He works for a large NHS Mental Health Trust (CNWL) both in acute and community settings. His role also includes management, research and service development in music therapy and arts therapies, particularly for people with acute and severe mental health problems. Mario has experience working with children and adults with a range of learning difficulties. He also works as a freelance pianist and teacher and lives and works in London.

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Publication history: Submitted 31 January 2015; First published 31 March 2015.

This extremely well-crafted book is the second volume of a triptych, a three-volume work based on the fruits of a six-year interdisciplinary study. The first volume, *Musical Asylums: Wellbeing through Music in Everyday Life* is written by DeNora (2013) and the third book, titled *Musical Pathways for Mental Health, co-written* by Ansdell and DeNora (to be published). Although the study was mainly conducted in the field of mental health, these works, and particularly this second volume, will speak to all areas of music therapy and also music and health in general. Ansdell leads the reader through an in-depth journey outlining in detail an ecological perspective, which has become a theoretical backbone of what is now termed Community Music Therapy. It needs to be highlighted, though, that Ansdell explicitly wrote this book for both professional music therapists and musicians working in various fields related to music and health; essentially, for people who "appreciate how music addresses human needs" (p. xvii).

The structure of the book leads the reader through key aspects related to music, music therapy and music in health, always keeping music firmly at the centre. It includes multiple perspectives from musical, ecological, developmental, social, and philosophical theories. As stated in the Series Preface, this volume "presents an ecological framework for understanding the key continuities between the specialist area of music therapy and people's more everyday experiences of how music promotes wellbeing".

The reading experience is continuously kept alive with regular vignettes, descriptions or interviews related to music therapy and other significant musical experiences. Throughout the book, the author weaves together the voices of so-called 'informants' creating an intriguing polyphony. These informants include 'voyagers' (e.g. music therapy clients), 'locals' (people with everyday music experiences) and 'scholars' (interdisciplinary theoreticians/thinkers). The multi-perspective stance that is evoked in the reader opens up a very stimulating, challenging and refreshing reading experience.

The main pillars of the book lead the reader from exploration of *Musical Worlds*, to *Musical Experience*, then focusing on *Musical Personhood*, opening up the perspective to *Musical Relationship* and *Musical Community* and finally into *Musical Transcendence*, which enters into less explored areas in music therapy.

Unsurprisingly, Ansdell writes from a stance deeply embedded in the Nordoff-Robbins heritage

of music therapy, which, to quote Ansdell, emerged "as a reaction to what they [Nordoff and Robbins] saw as the dominance of non-musical theories in the early phase of music therapy" (p.16). This quote, in many ways could be considered as a seed phrase, which resonates throughout the book. Thus, the work continues and develops the theoretical threads of music-centred approaches to music therapy, in particular the Nordoff Robbins approach, and underpins recent developments in its practice by including various theoretical perspectives. But it also deals quite fundamentally with the role and value of music in human existence and in relation to health and society.

The first two chapters (*Musical Worlds* and *Musical Experience*) explore the fundamental aspects of music and human experience. In *Musical Experience,* a fascinating journey through the themes of *Musical Space* and *Musical Time* opens the reader's mind to explore the heart of musical experiences. Ansdell ponders on the metaphors of "moving music", "musical landscape" and "music as moving force" (p. 78) very much drawing from and developing ideas formulated by Victor Zuckerkandl (1956, 1973). Further linking with ethnomusicology, linguistics and philosophy (e.g. Blacking, Johnson, Lakoff, Small), Ansdell makes the case for how musical experience is intrinsically connected to fundamental physical (bodily) and mental processes and how music is essentially experienced as a "continual interactive psychophysical coupling with the world around us" (p. 77). Ansdell establishes basic ideas of ecology in relation to musical events (tone relationships, people relationships, situational relationships) and the idea of 'musical affordances' (what music offers within situated action). Complex and abstract theoretical ideas are developed in reference to a broad range of literature; these, however, are balanced by vignettes of musical experiences and enable the reader to keep anchored in embodied musical experience.

The next chapter, *Musical Personhood*, takes the journey onwards into areas of music and identity, and introduces an ecological model of musical personhood, and the 'homo musicus', ideas that Ansdell has presented in previous books. Here, however, he elaborates on these concepts in greater detail, for example in investigating the musical parameters and qualities in *Music as Vitality*. Further examples from the 'informants' bring to life how core psychological and human needs can be met in music. Vivid examples illustrate the powerful role of musical characters, qualities or timeless archetypes in the psychological maturation process. As a reader I was inevitably drawn to recall and ponder deeply on my own musical experiences and encounters, which is one of the many strengths of this book and makes it particularly valuable for music therapists.

As we enter into the chapters dealing with *Musical Relationship*, the focus now turns on connectedness and the nature of human relationships in music and also specifically within the music-therapeutic context. Ansdell elaborates on the discovery and formulation of 'communicative musicality' by Trevarthen (2002), again exploring topics of companionship, musical co/inter subjectivity and giving due attention to musical dialogue and musical meeting, where he also draws from such influential thinkers and writers such as Buber, Bakhtin and Stern.

In this context Ansdell offers a critique of what he calls the medical and managerial models of care and points to the risks of demoralisation or loss of genuine relationships of care. Undoubtedly, this will ring a bell in the reader's mind and appears justified: "Where problems are seen only as needing to be treated and fixed, separable from the person who has them, monologue will dominate" (p. 164). However, one might also wonder how medical professionals would question generalisation about the so-called 'medical model'.

The critique of the understanding of therapeutic relationship as "a rather fixed thing" (p. 166) stemming from psychotherapeutic and medical traditions might be challenged, too. Particularly in mental health, the insights and knowledge gained from these disciplines in recent years can be as valuable for music therapy as those from other interdisciplinary fields. Further, they need not be excluding or denying an ecological perspective, rather complementing or even converging, particularly in the light of new developments in mental health such as the 'Open Dialogue approach' developed in Finland (Seikkula et al. 2006).

What follows includes an intriguing account of interdisciplinary research and microanalysis of a music therapy case looking at 'affect modulation' using Stern's 'microscopic method'. Here, Ansdell illustrates some theoretical concepts introduced in earlier chapters (musical time/space) again bringing to life and connecting the various threads in this book. From here the journey leads towards deep and fascinating explorations of musical companionship, hospitality, belonging (including a chapter on the politics of musical belonging), community and ritual, in which the reflection on 'musical utopia' is most thought-provoking.

The book culminates by treading into a less explored territory in music therapy, a welcome step. Having explored in depth the role of music in human community, the final part titled *Musical Transcendence* opens up what might be called the 'transpersonal' in music. Ansdell shines a light on people's musical experiences which are on the threshold of dimensions which transcend the personal and communal realities; "spiritual experiences that take us out of the narrow confines of the self" (p. 257). Referring to Bateson and Bateson (1988), amongst others, he shares various theoretical perspectives on this subject, as well as moving and intriguing examples from his informants who talk about significant experiences from various cultural and musical backgrounds, including musical ecstasy and altered states. Reflecting on these experiences, Ansdell muses whether "music may still be our best help in both reaching and protecting such everyday transcendence" (p. 272).

The book comes to a close in reflections on *Musical Hope* and here Ansdell reconnects with the simple and powerful concept of the 'music child', developed by Nordoff and Robbins, a concept that "there is a core wholeness and healthfulness to all of us that we can find particular access to through music" (p. 294). The reader is led to a place of simplicity after a complex and thoroughly enriching, challenging and inspiring reading experience. Ansdell concludes by pondering on the "perhaps radical" (p.295) statements found in this book (not least of all in breaking down the boundaries between 'music in music therapy' and 'music in everyday life') and concludes very aptly with *The Love of Music*.

I highly recommend this book to any music therapist, musician and music lover.

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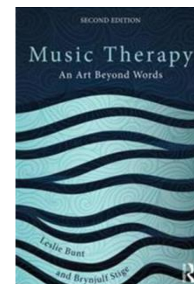
Book review

Music Therapy: An Art Beyond Words (2nd Edition) (Leslie Bunt & Brynjulf Stige)



Reviewed by Stine Lindahl Jacobsen

Title: Music Therapy: An Art Beyond Words (2nd Edition) | **Authors:** Leslie Bunt & Brynjulf Stige | **Year:** 2014 | **Publisher:** Routledge | **Pages:** 255 | **ISBN:** 978-0415450690

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This second edition of Leslie Bunt's book from 1994 is a well-guided journey through historical, clinical, theoretical and research-based perspectives of music therapy bringing us to the present day by both Leslie Bunt and Brynjulf Stige. New areas of clinical practice across the lifespan are described and these are combined with inspirational dialogues concerning the profession and discipline of music therapy. The authors are clear on changes and additions made in the second edition including more descriptions of music as a resource and music as part of community with deep respect for individual cultures, nations and beliefs. No particular theoretical stance or clinical approach is favoured and an admirable aim of uniting music therapists despite cultural, clinical or theoretical differences is evident throughout the text. The book consists of an introduction followed by nine chapters in which the first three chapters form the basis of understanding music therapy history, music therapy approaches or models, and the core elements of music. The next four chapters focus on music therapy practices and give illustrative case examples supplemented with both theoretical and research perspectives; their relevance to the examples has the effect of making music therapy come alive. The final two chapters discuss dilemmas and challenges which face music therapy as a profession and as a discipline; this is followed by an image-evoking epilogue described via a dialogue between the two authors.

Introducing the book, the authors connect readers with the everyday experience of music to explain what music therapy is all about. This includes a wish to further develop an ecological focus in presenting music therapy and a discussion on views pertaining to health and illness. The mix (or hybrid) between British and Norwegian perspectives and cultures seems appropriate in seeking to create a depth of analysis and an overview which favours no one singular stance.

Chapter 1 tells the story of music therapy as both a health profession and a music profession, looking at how different societies have integrated what music therapy has to offer. Depending on different needs in societies throughout history, different approaches and definitions have evolved as the process of registration and recognition is

unique for each nation. Different areas and activities are briefly described and the focus of looking across the lifespan in the subsequent chapters is introduced. Complex questions are asked which make good arguments for the purpose and aim of the book.

Chapter 2 opens with two clinical case examples which are presented and reflected upon from different theoretical perspectives. These include medical, behavioural, psychodynamic, humanistic, transpersonal and culture-centered perspectives (of which the latter two may permeate the former four). A presentation of thoughts concerning community, feminist, resource-oriented and music-centered stances affords readers a broad overview of music therapy. Theories are presented to support clinical examples illustrating how different perspectives might interconnect. This helps to portray how some stances may be more flexible than others. When looking at the benefits of music therapy, the needs of clients and the type of information that can be obtained, the authors might have included reflection upon the growing field of music therapy assessment and microanalysis since 1994. These aspects, however, are addressed later in chapter 7 when looking more generally upon music therapy as a profession.

In chapter 3 the core elements of music and how these elements affect us as humans are presented. Once again different musical/psychological perspectives and research studies are included thereby giving a thorough insight into how music works and how it is used in music therapy practice. For the outsider this is a good introduction while for music therapists it revisits the core concepts of our field by looking upon them through more or less familiar lenses.

Chapter 4 is the first chapter to consider music therapy with different age groups. Child health is the initial focus and it quickly becomes clear that this chapter has been thoroughly revised to bring it up-to-date with contemporary theories of Stern and Trevarthen (see Malloch & Trevarthen 2009; Stern 2000, 2010). This is supplemented with significant work from music therapy clinicians and researchers from the last twenty years. Affect attunement, communicative musicality and work with families are elaborated upon and nicely linked with illustrative case examples.

Music therapy and adolescent health in chapter 5 begins with a thorough understanding of young people and adolescents, bringing forth new perspectives such as children's rights, stigma and the problematic use of music. The highlighting of differences between a resource-oriented approach and assessment of pathology seems to slightly favour a more group and community-oriented approach. However, the authors still point to the fact that contexts and needs differ; this is illustrated through clinical case examples and qualitative and quantitative research studies which advocate how music is a powerful resource for young people.

Chapter 6 starts by describing how each client's relationship with music is different. The clinical examples in this chapter include adults with learning disabilities, mental health issues, neurological injuries, cancer and palliative care. The case examples illustrate different models and techniques such as analytical and resource-oriented approaches, active and receptive techniques, and activities in music therapy. The existential curative factors of group work suggest there has been a change in clinical music therapy practice from an individual focus to a more community and group-oriented focus. The presentation of research is more detailed in this chapter with different kinds of research being discussed while the subject of research hierarchy is considered in chapter 9.

In chapter 7 music therapy with elderly people completes the circle of looking across the lifespan. Refreshingly, the chapter starts with looking at how older adults use music to enhance wellbeing and sustain a meaningful life, keeping isolation and loneliness at bay. Music is described as a health resource and is not only intended for older adults who may be physically frail. Cognitive-behavioural, humanistic and psychodynamic approaches are discussed when considering people with dementia. This is achieved by mixing, narratively, theoretical reflections with clinical case examples; thereby cleverly and smoothly linking the case examples together. The challenges of musical preferences and connecting with people with dementia become crystal clear to the reader and Stige's own experience within this field seems quite evident.

Chapter 8 aims somewhat ambitiously to discuss music therapy as a profession. Music therapy strives to ensure and foster health and to meet its purpose in society. Yet this happens in many different ways and places, and with a range of medical and contextual aims. An example of a day in the life of a music therapist is used to illustrate the many different roles we have and our level of expertise in being flexible. The authors talk of three axes: the what, how and where of the music therapy profession, offering a simple model to explain their point. Interdisciplinary collaboration is described by pointing out how music therapy can supplement and enlarge fields of physiotherapy, education, music and health; yet how music therapy also offers something unique.

In the final chapter the authors consider music therapy as a discipline and are not afraid to include the tensions and struggles we might experience when art and science can pull us in different directions. The dilemma of describing nonverbal experiences with numbers and language is portrayed, and opposites such as striving for objective or subjective knowledge are discussed – again without favouring any one stance. The authors thoroughly prove their point that a discipline is not only a body of knowledge but also a culture. Bunt and Stige urge music therapists to embrace tensions and contradictions using different perspectives and approaches as ways to understand, instead of ways to argue. The aim here is to allow multiple perspectives and multiple truths to co-exist in a hybrid cultural mix. The epilogue of the book is a wonderful image of two knowledgeable men sitting and discussing in front of a warm fire, making recipes of future nourishing salads for the music therapy culture and community.

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Book review

Group Music Therapy: A Group Analytic Approach (Alison Davies, Eleanor Richards & Nick Barwick)

Reviewed by Mitsi Akoyunoglou-Christou

Title: Group Music Therapy: A Group Analytic Approach | **Authors:** Alison Davies, Eleanor Richards & Nick Barwick | **Year:** 2015 | **Publisher:** Routledge | **Pages:** 183 | **ISBN:** 978-0-415-66594-0

Mitsi Akoyunoglou-Christou is a registered music therapist (US), holds a Bachelor's (1987) and a Master's (1990) in Music Therapy from Michigan State University as well as a PhD in Musical Sciences, Music Therapy (2014) from Ionian University, Corfu, Greece. She received her piano diploma (Athenaeum Conservatory) with pianist N. Semitekolo. She works as a piano instructor and a music therapist at the Aegeas/Nakas Conservatory in Chios. Her research interests are on ethno-music-therapy, children with emotional challenges and grief. She is a member of ESPEM and WFMT and a member of the advisory editorial board of *Approaches*.

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> "By the crowd they have been broken, by the crowd they shall be healed" (Marsh 1933, cited in Davies, Richards & Barwick 2015: 29).

As the title suggests, *Group Music Therapy: A Group Analytic Approach,* this book provides a bridge between the group analytic theory that originated in Great Britain and its application in group music therapy. *Group analysis*, a term coined by Burrow in 1925, has evolved greatly since Pratt (who is considered the founding father of group therapy) conducted the first therapeutic groups in Boston, Massachusetts, at the beginning of the 20th century (Behr & Hearst 2005). *Group analysis* is also the formal label applied to the therapeutic approach of the British psychoanalyst Foulkes, where "the individual is being treated *in the context* of the group with the active participation of the group" (Foulkes & Anthony 1957/2003: 16).

Within the last decade, group music therapy has become a topic of interest for researchers, practitioners and clinicians, resulting in a continuously growing body of literature (e.g. Ahonen-Eerikainen 2007; Amir & Borden 2013; Cho 2013; Davies & Richards 2002; Hessenberg & Schmid 2013; Jackson & Gardstrom 2012; Pavlicevic 2003). A great addition to this list is this newly published book *Group Music Therapy: A Group Analytic Approach* by Davies, Richards and Barwick, which investigates analytic theories behind group work and its relation to group music therapy. The authors are clinicians and researchers practising in the UK and they come from diverse clinical backgrounds, which allow them to offer their different perspectives concerning group work in analytic terms within music therapy. Barwick, a group analyst himself, draws mainly from Foulkes' group analytic theory to set the stage for this book, a theory which takes into account both individual analytic approaches and 'one-to-one' practices as well as group dynamics. Davies and Richards, both music therapists and psychoanalytic psychotherapists, focus on the exchange between music therapy, group improvisations in music and

group analysis, offering theoretical and clinical perspectives.

The book consists of four parts, a total of 13 chapters and each chapter has one author. The first part covers historical background on group music therapy in the UK, the second part elaborates on group analysis theory, the third part focuses on providing an understanding of early development, attachment-based thinking in therapy and clinical examples of group music therapy, and the final part includes a few clinical music therapy vignettes and analyses the benefits of co-therapy and of experiential groups within music therapy training programmes.

In the first chapter, Davies focuses on the historical perspectives of group music therapy with references to the work of music therapists who have played a major role in the development of group music therapy (analytic or otherwise) in the UK, namely Alvin, Priestley, Nordoff and Robbins, Streeter, Woodcock, Towse and Odell-Miller. The succeeding chapter includes Richards' interview with Odell-Miller on the development of group work in music therapy in the UK. In this interview, Odell-Miller narrates her path on group work, the group improvisation trainings with Alfred Nieman, the 'interactions' with Juliette Alvin as head of the training programme at the Guildhall School of Music and Drama, working together with Tony Wigram, the experiential music therapy groups and the supervision groups for students in music therapy programmes in the UK.

The second part consists of five chapters and focuses on group therapy and group analysis. In these chapters, Barwick presents Foulkes' theory and belief that it is possible to "do therapy" in groups, explaining his notion that individual psychological disturbances can be viewed as an expression of disturbed interpersonal processes. In other words, a group-analytic group can be viewed as a microcosm of society. He elaborates on the holistic approach which was "deeply informed by Gestalt psychology" and points out the "neurological metaphor" Foulkes developed to describe the group as a "communicational network" analogous to the neuronal network of the brain (p. 27). In the following chapters, Barwick analyses the three core aspects adopted from psychoanalysis (the unconscious, free association and transference) and deepens further within group-specific processes and phenomena. In the fifth chapter, the author shifts the focus to Bion's basic assumptions on group work, highlights differences between Foulkes' and Bion's approaches and completes his narrative with Nitsun's anti-group concept, which can function as a possible bridge between group analysis of Foulkes and the practice of Bion.

Davies and Richards elaborate on the developmental perspectives of group music therapy in the third part of the book. Davies focuses on the early years of a child for an understanding of how relationships progress and mature throughout life within the various social groups. The author first explores the importance of dynamic forms of vitality and empathy for the music therapist. Then, Davies elaborates on the value of focusing on transitional phenomena within the music therapy space since, for the developing child and mother, the relationship established through auditory and musical dialogue strengthens all subsequent relationships. Richards focuses on Bowlby's evolutionary theory of attachment, discusses how it relates to some aspects of group analysis and provides clinical examples of improvisations in group therapy. The author argues that improvised music in a group offers players various ways to explore their relating with one another through co-creating music and quotes Foulkes' musical metaphor:

> "if we hear an orchestra playing a piece of music, all the individual noises are produced each on one particular instrument; yet what we hear is the orchestra playing music. […] In the same way mental processes going on in a group under observation reach us in the first place as a concerted whole" (p. 108).

The final part of the book includes a chapter with a series of clinical vignettes contributed by several music therapists from the UK and drawn from group music therapy practice with various clinical groups. In the concluding chapters, Davies discusses the benefits of co-therapy work, supervision in a co-working relationship, and the student experiential groups that have become a key element in all music therapy training programmes in the UK. As Davies states:

> "groups can be very powerful places and the experiential group is no exception. […] [It] can greatly enhance participants' personal growth as future music therapists and the work that they may do with groups themselves" (p. 151).

As a whole, the book provides a rather informative way of bridging the theoretical background of group analysis with group music therapy, focusing on music therapy practice in the UK. The theoretical perspective of group analysis is eloquently presented by Barwick, giving ample information on group work, the 'conductor's' role and position within the group and the development and

advancement of Foulkes' group analysis. From a group music therapy perspective, the clinical cases included reflect both free improvisation approaches and more structured group activities in a variety of populations, giving the reader quite a wide range of practical examples.

A literature review on group music therapy would have been a helpful addition, given the established tradition in the UK of using group work in music therapy. The first chapter provides interesting historical information on the development of group music therapy but highlights only clinicians practising in the UK. The same is true for the clinical vignettes that are included; all are contributed by clinicians practising in the UK. For a music therapist interested in the Foulkesian group analysis model, this book can be a great asset. Yet information and literature reflecting research and practice on group music therapy from other countries could strengthen the book's use by music therapists with an interest in group work. Furthermore, the book appeared more focused on theoretical aspects of group analysis and would have benefited from additional clinical group music therapy examples.

Overall, this volume provides a needed addition to an earlier collection edited by Davies and Richards, *Music Therapy and Group Work: Sound Company* (2002), by elaborating on psychodynamic theory which informs the authors' approach to music therapy. The major contribution of this work is that the authors offer a good understanding of group work and group analysis theory and provide considerations for the application of the theoretical framework within group music therapy. The result is a notable resource that can be quite helpful for music therapy students and practitioners who are working or have an interest in working with groups within the analytical approach.

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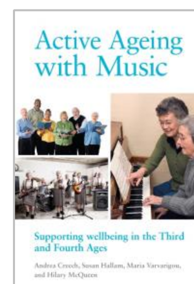
APPROACHES

Book review

Active Ageing with Music: Supporting Wellbeing in the Third and Fourth Ages (Andrea Creech, Susan Hallam, Maria Varvarigou & Hilary McQueen)



Reviewed by Clare Monckton

Title: Active Ageing with Music: Supporting Wellbeing in the Third and Fourth Ages | **Authors:** Andrea Creech, Susan Hallam, Maria Varvarigou & Hilary McQueen | **Year:** 2014 | **Publisher:** Institute of Education Press | **Pages:** 184 | **ISBN:** 978-1-782770-29-9

Clare Monckton qualified with a MA in Music Therapy from Roehampton University in 2009. She has worked full-time for MHA Care Group since 2010 as part of the music therapy service, providing music therapy in care homes for older adults with dementia. Clare has recently presented at the World Congress of Music Therapy in Austria (2014) and is currently Dementia Network Coordinator for the British Association for Music Therapy (BAMT).

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Active Ageing with Music provides an exploration of the use of music from the authors' perspectives of work with older adults. The book focuses on data collected from *The Music for Life* and other projects, which are discussed in detail at the beginning of the book. These projects act as a point of reference for the experience of other professionals working with older adults.

All four authors come from both educational and music-orientated backgrounds, with an association at the Institute of Education, University of London. Creech is Reader in Education, following an orchestral career. She has been director of Community Music School in the Republic of Ireland and co-director of several research projects and has completed her PhD in Psychology of Music. Hallam is Professor of Education and Music Psychology and has pursued a career as a professional musician and educator. McQueen has studied music, psychology and education and is currently a tutor at the University. Varvarigou is a visiting research associate, also working as a Lecturer in Music and Performing Arts at Canterbury Christ Church University and Senior Researcher at the Sidney de Hann Centre for Arts and Health.

The projects include *The New Dynamics of Ageing Programme*, which incorporated the *Music for Life Project*. This project partnered with The *Silver Programme* at The Sage Gateshead, *The Connect Programme* of the Guildhall School of Music and Drama and the Westminster Adult Education Service. Musical activities within the project included small and large groups, instrumental classes; including keyboard and musical appreciation. The control group activities included languages, art and craft, yoga, a book group and a social club. Facilitators of the music groups seemed to be approaching the projects as musicians, playing a range of instruments, some holding Masters and Diploma qualifications, 6 of the 14 facilitators hold a teaching qualification.

The overall aim of the book is established early on with the knowledge, experience and belief of the power of music to support positive wellbeing and quality of life among older people.

As a music therapist working full-time with older adult client groups, it is encouraging to see a book

dedicated to the use of music with adults in the later stages of life, acknowledging the impact and power of music on health and wellbeing. There have been various studies in recent years looking at this effect of music and this book begins by setting out the research methods used within the project with reference to past studies. The early exploration of the term 'older people' in the book seems quite rigid at times, with reference to the third and fourth ages of life. However, it is acknowledged that assigning chronological age to the stages of later life is difficult, often with blurring lines. There are also signs that the way we are now culturally experiencing older age is changing as individuals lead increasingly active lives with a significant increase in life expectancy.

Divided into three sections, the book covers a wide area of thought, opinion and experience of music projects run for an older age group, drawing on the qualitative research data from the *Music for Life* project. Using a control group, data collection comprising mixed methods was applied from questionnaires, focus groups and individual semi-structured interviews, observations and consultation. Results were analysed and broken down into many individual components, including participant occupation, musical preferences and purpose. Section one looks into the use and effect of music on individual people's experiences of wellbeing (including cognitive, physical, socio-emotional wellbeing) and the importance of maintaining and developing social networks in later stages of life. Throughout the book there is the recurring idea of the importance of active ageing in the promotion of wellbeing and health, with reference to the guidelines and framework identified by the World Health Organisation (WHO 2002). Points and ideas are put forward by the authors following their findings from the various projects and then related to other similar and relevant studies.

Section two looks into how projects, groups and sessions are run, the practicalities of time, location and venue alongside the implications of facilitating groups for adult learners. Within this section, chapter seven looks at intergenerational music making. Within the *Music for Life* project, activities included those "which older adults provide service to children or youth; those in which children or youth assist the elderly; and cooperative programmes where different generations collaborate on activities as equal partners" (pp. 99-101). The examples used provide positive conclusion and impact of the sessions for both the younger and older generations but also identify the facilitator as falling into yet another generational group. All parties seemed to gain significant benefits and pleasure from the experience, with the sharing of knowledge and perhaps vitality, but I also felt this went a long way in dispelling the myths and preconceptions both age groups have of their counterparts. Within this section the authors look into the anxieties older people have about accessing music groups and developing musical skills at a later stage of life. The authors discuss how to structure sessions, which teaching style can be most effective, and what to avoid, the importance to engage and inform without being condescending, while maintaining support, interest and enthusiasm.

Alongside the considerations previously mentioned, the participants, facilitators and authors who later analysed and reviewed the projects all acknowledge the difficulty in reaching out to this specific population. Promoting and advertising various community projects and groups was identified as a difficulty. The above is acknowledged by both facilitators and participants. Participants indicated they were often unaware that such groups were available. Furthermore, facilitators highlighted the financial implications and restrictions of setting up, advertising and running community groups. It was noted that issues of location, accessibility and cost had a significant impact on the potential success of groups. In addition, it was found that older adults still carry commitments to their own family (e.g. acting as a primary care provider) as well as being involved in other activities and obligations associated with an increasingly active lifestyle in later years.

When thinking about offering musical interventions to older adults, the authors look at the elements of musical interaction that can reinforce positive wellbeing for individuals and refer to the therapeutic benefits of music, both physical and emotional. When thinking about music and health, the authors discuss community music therapy; while acknowledging the differences between community music and community music therapy, the authors see "a cultural and social link between music therapy and music and health in everyday life" (p. 62). As a reader I would have liked to know more about the authors' perspectives on music therapy in relation to other therapeutic interventions with this client group and also in relation to their work and research.

Throughout the book, the authors – or perhaps the participants themselves – dispel the myth that older adults are unable to learn new skills. Reference is made to the differences and difficulties in supporting and promoting adult education into the later stages of life. Testimonials

from the participants discuss achievements made as a result of participation in the projects, through singing in vocal groups and choirs, learning new instruments and performing within the local community. Moreover, they discuss the importance of songs related to reminiscence, past experiences, knowledge and cultural identity. Alongside the practical achievements gained by the participants, the experience of positive personal and social benefits were felt to be just as important.

Although challenges and difficulties regarding supporting those in old age are acknowledged by both the authors and facilitators, there does still seem to be a gap in how we are able to reach out to those in the later stages of life, particularly for those experiencing health, social or financial difficulties. The outreach to this client group still feels limited; these limitations are identified by the participants and documented by the authors as part of the analysis of the various projects as well as a result of funding and limited resources. Much can be learnt from the experiences and views of the participants whom we as professionals working through the medium of music are trying to engage and support.

The scope of the projects did not extend to individuals with age-related health conditions. The work discussed by the authors focuses on older adults who remain fairly independent and active, able to access groups independently with active engagement and participation while contributing to the various projects. Although the positive impact of music for those with dementia is identified, it is unclear what provision would be made or if inclusion to community projects such as these would in fact be possible. The various aspects of ageing could be addressed, as the process of ageing cannot be ignored, whether it is impacting on emotional, social or physical wellbeing. Can these projects support those who may be limited by conditions related to age, as their needs change or progress? Can they still be engaged musically to meet the aims and outcomes of the various projects?

The authors acknowledge limited research in the use of music to support active ageing, and particularly how it works to support older adults. However, the publication of this book itself is a step in the right direction in opening up dialogue about the positive work taking place with older adults and the benefits of musical intervention, participation and the results achieved. The opinions, views and experiences of the participants are the greatest testimony to the use of music within the community projects. As a practitioner working in a related field, it is encouraging to learn from current work and research in relation to the ongoing development of my own understanding and practice, highlighting scope for future research.

Whether offering community music projects, community music therapy or music therapy, practitioners need to be looking at how music can be used effectively to support and promote improved wellbeing with older adults. What is it about the use of music as an intervention that can enhance the active experience of older adults, how does it work compared to other modalities and can it provide long term benefits?

The authors have succeeded in demonstrating the use and benefits of music in the later stages of life in promoting personal development, social inclusion, occupation and even health benefits with studies showing singing groups to be a cost-effective intervention in promoting positive mental health (see also Clift et al. 2012); any move to develop and implement interventions to work in collaboration with medical and pharmacological treatments has to be a step in the right direction, alongside social inclusion and other positive benefits to both physical and mental health of older adults.

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Conference report

Music Therapy and Oncology Symposium

Mariza Neiada

Music Therapy and Oncology Symposium

7 February 2016

Athens, Greece

Mariza Neiada is a music therapist from Athens and is currently working with children in special education settings. Mariza studied music therapy and vocal performance at Berklee College of Music in Boston, Massachusetts and completed the Neurologic Music Therapy certification training. From January 2013 to January 2014, Mariza worked as a contracted music therapist at South Shore Conservatory in Massachusetts. From June 2014 to June 2015, she coordinated and participated in a programme which focused on music therapy and parent-infant bonding in cooperation with the Child Psychiatric clinic of a Greek state paediatric university hospital. Since February 2015, Mariza has been working at Psychomotor Athens and conducts individual music therapy sessions with children who have developmental, physical and emotional needs.

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On 7th February 2016, a scientific symposium regarding Music Therapy and Oncology was held at the Acharnes town hall in Acharnes, Athens (see also Acharnon and Breed 2016). Organised by the Greek Cancer Society (EAEF) in cooperation with the Hellenic Association of Certified Professional Music Therapists (ESPEM; www.musictherapy.gr), the symposium included a series of presentations highlighting the effects of music therapy in oncology settings.

The symposium opened with a talk given by Greek Cancer Society representative and president Panagiotis Kazanas. Kazanas emphasised the importance of the public's participation in the Greek Cancer Society's activities as well as the significance of blood donation. Music therapy was presented as a complementary therapy that can have significant effects on oncology patients, along with medical treatment. Studies have shown that it can help with pain management, decrease side effects like nausea and emesis, reduce anxiety and generally enhance coping skills (Cai, Qiao, Li & Lu 2001; Harper 2001; Horne-Thompson & Grocke 2008).

The first presentation included an overview of music therapy and its effect on cancer treatment. The main focus was on Guided Imagery and Music (GIM) and was given by music therapist and primary GIM trainer Evangelia Papanikolaou; the founder of SONORA, the only GIM-related Greek organisation that aims at promoting education, research and clinical programmes in music therapy (Sonora Interdisciplinary Association of Music Therapy and Research 2014). GIM was described as a non-intrusive method that is based on music listening and narration. Music may activate the thinking process and emotional connection, represented by archetypal images that the individual visualises during the therapeutic process. GIM may help revive emotions, sensations and thoughts that might provide insight on deeper personal needs. In practical settings, GIM group sessions are facilitated at the Association of Cancer Patients and Friends Volunteer Doctors (KEFI),

Photograph 1: Symposium poster

which is a centre in Athens aiming to provide emotional, psychological and social support for cancer patients and their families, as well as informing and educating society about cancer (Association of Cancer Patients & Friends Volunteer Doctors Athens 2017).

These group sessions were described as workshops which were offered to cancer patients at KEFI and consist of 12 consecutive two-hour sessions. During the workshop a conversation about common topics is held followed by four to twelve minutes of listening to music. The group then shares the images, the sensations and the emotions they experienced after listening to the music. A research proposal from SONORA in cooperation with Aalborg University (Denmark), Areteio University Hospital (Greece), and global healthcare company NOVARTIS was introduced regarding GIM as a psychological therapy for women for women during active treatment for gynecologic cancer.

The second presentation, given by music therapist Kandia Bouzioti who specialises in vocal psychotherapy, emphasised how music therapy can support cancer patients within a hospital setting. This presentation was a case study of a cancer patient in a hospital in New York who was diagnosed with mantle cell lymphoma. Clinical material in the form of audio and video recordings was presented to illustrate the importance of the therapeutic relationship between the music therapist and the patient, which in this case was enhanced through singing. Additionally, the importance of empowerment and development of coping skills through self-expression was underlined.

Moreover, the third presentation given by music therapist Christina Kalliodi, highlighted how music therapy can enhance family and medical staff support in a hospital setting. The importance of opportunities for self-expression of the medical staff and the families of the cancer patients was considered as equally significant as the self-expression of the patients.

The final presentation was given by music therapist Evangelia Arachoviti, who has a background in musicology and improvisational music therapy, in which she elaborated on “Inter-related music therapy with a cancer patient during the fourth stage of treatment” in London. During this presentation, the importance of improvised music therapy between the patient and the therapist with regard to emotional needs was analysed. Music may be the medium of expressing elements that cannot be verbalised.

Photograph 2: Stergios Pediaditis (vice-major of Acharnes), Evangelia Papanikolaou, Candia Bouzioti, Christina Kalliodi, Evangelia Arachoviti and Panagiotis Kazanas

At the end of the symposium there was time for discussion and audience participation. Since this was the first symposium on music therapy and oncology in Greece, its importance shall be underlined because it provided evidence and examples of how music therapy can have a significant effect on cancer patients. It also educated the community on this relatively new

complementary practice, which is unknown to the majority of the Greek population. Furthermore, the symposium promoted ESPEM, as the audience had the opportunity to be informed about the organisation's purpose and activities. The conclusion of the symposium was that music therapy could be a vital complementary therapy in oncology settings in Greece. The difficulty, however, lies in insufficient government funding and dysfunctional public healthcare in Greece during this period of economic turbulence. In general, music therapy in Greece is underdeveloped (Tsiris 2011). A series of gaps and problems regarding professional recognition and academic training are at the heart of the challenges that music therapy faces in the country. Along with academic recognition, frequent seminars, events and symposiums like this one are needed for the promotion of music therapy on a national basis in Greece. Finally, the symposium ended with a delightful vocal performance by Voice Box, a vocal world music ensemble.

Photograph 3: Performance by Voice Box

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Conference report

The Third International Symposium for Music Therapy with Adolescents

'Adolescent development and music therapy: Dialogues in action'

Kassandra e'Silva

The Third International Symposium for Music Therapy with Adolescents
'Adolescent development and music therapy: Dialogues in action'

11 April 2016

Queen Margaret University, Edinburgh, UK

Kassandra E'Silva is a music therapist practicing in various locations around Scotland. Working both in private practice, and with the charity Nordoff Robbins Scotland, she has worked with infants, children, adolescents, young people and adults. Currently, she works largely within primary and nursery schools with children with additional support needs.

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This report summarises the third International Symposium for Music Therapy with Adolescents: *Adolescent Development and Music Therapy: Dialogues in Action,* which took place in Edinburgh in April 2016. Hosted at Queen Margaret University (QMU), Ian McMillan (Head of Division, Occupational Therapy and Arts Therapies) and Petra Wend (Principal and Vice-Chancellor), welcomed the symposium delegates to the university and described the efforts of Philippa Derrington in organising the event. It marks the first music therapy gathering of its kind in Edinburgh, and contributes to Derrington's aims when taking the role of Head of Course in 2013 to make QMU a hub for music therapy in Scotland, and to encourage diversity of practice and research.

The event was sponsored by Queen Margaret University, East Lothian Youth Music Forum (ELJAM), and The Music Therapy Charity. Derrington thanked the sponsors and welcomed the delegates, highlighting the importance of collaboration. She explained that in 2012, a group of music therapists and professionals with a shared passion for their work with adolescents met while at the European Music Therapy conference in Oslo. During an informal conversation on that occasion, this group agreed to meet once a year to discuss and debate their work. The result was the birth of the International Symposium for Music Therapy with Adolescents held first in Verona in 2014, and then in Bergen last year. The one-day event in Edinburgh consisted of seven presentations, from various international professionals, around the theme: *Adolescent Development and Music Therapy: Dialogues in Action*. Each presentation explored the variety of approaches, thoughts and experiences of working with this client group.

Photograph 1: The presenters (from left to right): Steve Cobbett, Louise Neale, Philippa Derrington, Suvi Saarikallio, Katrina McFerran and Andreas Wölfl

THE DEVELOPMENTAL DRIVE TO PERFORM IDENTITY THROUGH MUSIC

The keynote speaker was Katrina McFerran. Opening with her own lyrics to Eminem's "Lose Yourself", McFerran performed her identity for the audience – revealing and sharing who she is, and demonstrating her strengths, vulnerability and weaknesses "in the special way that music can". She went on to discuss the ways that teenagers appropriate music, and use it in various ways to perform their identity (DeNora 2007; McFerran & Saarikallio 2013). She challenged the developmental notions of the sequential nature of development, positing that identity formation does not happen exclusively in adolescence, nor does it conclude at the end of adolescence. She also questioned the idea that this is a time of particular risk to the adolescent. Instead, she asserted that adolescence is a time of potential and hope. However, McFerran also acknowledged the limitations of music, and that young people will put limits, themselves, on how helpful music can be. She highlighted that adolescents may appropriate music to reinforce their depression or rumination and encouraged a move away from the simplistic view that music is a predictable force that will heal, or harm, stating that young people deserve to have their consciousness raised that music is not simple.

YOUTH AND AGGRESSIVE BEHAVIOUR: DEVELOPMENT TASKS – AGE-APPROPRIATE AND DEVELOPMENTAL RISK FACTORS – CHANCES OF MUSIC THERAPEUTIC INTERVENTION

Andreas Wölfl offered that it makes sense to be systematic and to think about developmental theory when working with adolescents. He agreed that perhaps identity does not develop solely during the adolescent time period, but asserted that developmental theory was a useful framework when working with adolescents who have had much traumatic and developmental stress. Wölfl described various factors that should be taken into consideration, including the family world; and life world (political/economical/social/media etc.) of the adolescent. He reiterated that identity formation is harder during this time if the developmental tasks in each stage of development are interrupted. Furthermore, he added that the implicit working models of adolescents could become repeated cycles within a negative developmental career. However, he agreed fundamentally with McFerran that there is great potential for change during this time (McFerran & Wölfl 2015), specifically for changing implicit working models to disrupt negative development cycles. He demonstrated these concepts in two case studies. One of these

showed the Drum Power project (www.drumpower.eu) which uses affect regulation, empathy, and mentalizing tools within a developmentally based approach to emulate daily conflict situations and develop resolutions for these using new and creative tactics.

"HOW DO MY EMOTIONS SHOW IN MY MUSICAL DIALOGUE?"

Suvi Saarikallio discussed the emotional functions of music, including emotional self-regulation, emotional expression, communication and socio-emotional bonding. She went on to describe regulation strategies such as emotional distraction and emotional reinforcement, explaining that these differences in strategy may transfer to musical emotional perception. This, in turn, may also affect the depth of emotional response one might experience when listening to music based on empathy, emotional stability and agreeableness factors. For adolescents, Saarikallio posited that empathy levels may be related to conduct problems and, more widely, that general emotional competencies can relate to the ways we express ourselves in music. She explained that the use of music for diversion related to higher activity in the brain - where thinking shifts from negative to positive. She noted that the ability to divert emotional states through music differs significantly between depressed and non-depressed individuals, explaining that music is not so effective in self-regulation for those who are depressed. Saarikallio highlighted adaptive and maladaptive uses of music, and together with Gold and McFerran created a questionnaire of 13 items concerning adolescents' healthy and unhealthy uses of music (Saarikallio, Gold & McFerran 2015).

IMPROVISATION IN MUSIC THERAPY WITH ADOLESCENTS WITH LEARNING DISABILITIES

Louise Neale discussed her work with adolescents with learning disabilities at Key Changes in Hampshire. The hope is that music therapy will allow better participation and interaction in the classroom. She emphasised that adolescents with learning disabilities are, first and foremost, adolescents. Neale described how 36% of adolescents with learning disabilities have diagnosable psychiatric conditions. This is 6% higher than in normal functioning adolescents and these conditions may be linked to issues such as social exclusion, hardship in families and other difficulties which may, as Wölfl suggested, interrupt developmental tasks. Neale noted that adolescents with learning disabilities appear more willing to improvise than their peers without disabilities and are therefore, more open to the potential risk of improvising and the vulnerability innate in that process. She demonstrated these ideas in two case studies showing how improvised musicking can contain the fluctuating emotional states of these adolescents without the use of words, where there is no such thing as a wrong note.

MUSIC THERAPY AND THE DEVELOPMENTAL NEEDS OF YOUNG PEOPLE WITH SOCIAL, EMOTIONAL AND BEHAVIOURAL DIFFICULTIES

Steve Cobbett questioned how music therapy can meet the developmental needs of young people with social, emotional and behavioural difficulties (SEBD), and linked this to neurological theories. He described how factors such as trauma, insecure attachments to care givers, and coming from socially deprived backgrounds, may impact brain structure development in adolescents. He went on to discuss the instinctive responses to threat – fight, flight, fright – noting that adolescents with SEBD seem hyper-sensitive to perceived threat. Where the amygdala represents rational development, and the hippocampus represents cognitive development; Cobbett asserted that the former is more evolved in this client group. He explained that language systems may be underdeveloped, emotional literacy compromised and diminished mentalizing capacity experienced. However, Cobbett emphasised that brain structure can be rewired, and that therapy has the potential to do this. Music therapy specifically can offer the movement from non-verbal to verbal offerings within the process which can represent the neurological progression, and begin to enable clients to process traumatic events from an emotional level to a cognitive level. Similarly, it enables clients to experiment with control.

LIFE-LONG LEARNING PROCESSES IN MUSIC THERAPY – A CASE STORY FROM A SCHOOL SETTING

Viggo Krüger (Grieg Academy Music Therapy Research Centre, www.gamut.no) focussed on the concept of life-long learning and its relation to music therapy. He stated the importance of learning

which does not happen at school and questioned how it could be used within schools to diminish drop-out levels in Norway. Krüger explained that life-long learning incorporates formal, informal and non-formal learning. These occur in schools, in the day-to-day, and in activities which are organised but not formal, respectively. He described the growing NEET (Not in Education, Employment, or Training) population in Europe, and questioned whether music therapy might be possible solution, where adolescents may develop social and emotional skills and the accumulation of these skills might be processed. He posited that music therapists can be agents for promoting the necessary skills for accessing and coping with education. Krüger went on to describe his work with young people, some of which involves bringing the students into the community, such as performing in old age homes. Aside from making these young people visible, these activities also give teachers a new way of interacting with the children outside of school to create a wider learning community. Krüger emphasised that music education can be more than learning notation.

CONNECTING WITH ADOLESCENTS: DIALOGUES IN AND AROUND MUSIC THERAPY

Philippa Derrington highlighted the various people who interact with and surround young people and the ways in which dialogues occur with and around them. She discussed the Music Therapy Charity's Youth at Risk project which she led at Cottenham Academy in Cambridgeshire (Derrington 2012) and explained how the project gave voice to young people through interviews before and after music therapy. These conversations with the students demonstrated where things can start to go wrong in their lives, and highlighted where support is needed and where music therapists need to be. With video examples, Derrington described her approach as getting alongside young people, to empower and facilitate play, in whatever form that takes. Answering Krüger's question in a UK context, some students said that music therapy made them feel better about going to school and more motivated to learn. Findings from Derrington's research also showed that students enjoyed the space to talk and play within music therapy, and that the combination of these was reportedly the most unique and valuable aspect, concluding that music therapists need to listen to the young people.

Photograph 2: The presenting panel for closing questions and discussion with Viggo Krüger (far left)

THE MUSIC[1]

Musical interludes from young Scottish musicians were interspersed throughout the day, beginning with Baron Salmon – a finalist of the East Lothian Battle of the Bands 2015 competition. He performed two original pieces, "Lost You" and "Wild Things". Asked what music meant for him, he explained that he enjoys "writing songs 'cos it's a release of… stuff! Anything that's in your head that's difficult to say in words." He went on to paraphrase Aldous Huxley saying that music was, aside from silence, the only way to express that which was inexpressible.

Lucy Stannage was the winner of the East Lothian Battle of the Bands 2015, the prize of which is playing at Grandstand to a crowd of 4000 people. She played two of her original pieces called, "Archers" and "Crossfire." When asked what music means for her, she explained that it was a release, and it started at a time in her life when she was quite low. She looked to McFerran saying, "You know how you said music can save lives... well it actually did."

The band Sensatronic[2], comprising of John Pratt on vocals and "pizza boxes", and Matthew Ward on keyboard, also performed two original pieces: "Musselburgh Sea" and "Musselburgh Future." Ward, who is visually impaired, described how music is integral in the lives of the members of the band. He explained how music can connect people, allows self-expression, and described how music can help "cure us of minor stresses." He highlighted concerns about how disabled people cope with technology and how they may or may not be limited when trying to access music technology. Currently, Ward is working with Ableton to develop more accessible technology and music technology for disabled people.

At the wine reception hosted to conclude the symposium, music was provided by singer and pianist David Limmer – a recent graduate of the music therapy programme at Queen Margaret University. Limmer played an array of surprising and poignant arrangements of various pop songs, ranging from The White Stripes to The Rolling Stones.

[1] Video clips from the music performances are available on Approaches' YouTube channel.

[2] Sensatroniclab: www.facebook.com/sensatroniclab/

Photograph 3: David Limmer

CONCLUDING THOUGHTS

The symposium was an invigorating day of information, discussion and music. The inclusion of a music psychologist in the programme lent a fascinating perspective in understanding the emotional responses young people may experience when listening to music, as did the neurological aspects that were introduced by Cobbett. The differing approaches outlined were thought-provoking. The use of a developmental framework for music therapy with adolescents is appealing due to its systematic nature. However, McFerran's challenges regarding identity formation, age-appropriate behaviour and appropriation of music were compelling. Music is not a "black and white" entity, and neither can be the approach when working alongside and with adolescent clients. The consensus for the day was the potential for change innate in this time of development and the unique ability of music therapists to be well situated to offer appropriate support. The day concluded with much to think about, and the clear understanding that dialogues around this work should, and will, continue. The fourth International Symposium for Music Therapy with Adolescents will take place in Munich in 2017.

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Conference report

The 4th International Conference of the International Association for Music and Medicine (IAMM)

Amy Clements-Cortés

The 4th International Conference of the International Association for Music and Medicine (IAMM)

11-13 June 2016
Beijing, China

Amy Clements-Cortés, PhD, RP, MTA, MT-BC, FAMI, Assistant Professor, Music and Health Research Collaboratory, University of Toronto; Instructor and supervisor, Wilfrid Laurier University & Ryerson Chang School; Music therapist and registered psychotherapist. Amy has extensive clinical experience working with clients at end-of-life. She has multiple peer reviewed publications, including her new 2016 book *Voices of the Dying and Bereaved,* and has given over 100 conference and/or invited academic presentations. Amy is President of the World Federation of Music Therapy (WFMT), and Managing Editor of the *Music and Medicine* journal. She serves on the editorial review boards for seven international journals.

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In June 2016, I had the privilege and honour of attending and presenting at the 4th International Association for Music and Medicine (IAMM) Conference in Beijing, China. Attendees included music therapists, physicians, healthcare professionals, researchers, musicians and students.

It seemed timely for the conference to take place in Beijing considering that the development of music therapy in China has been growing steadily over the past two decades. The first music therapy academic programme was established at the Central Conservatory of Music by Professor Tian Gao. At present, 12 universities in China offer music therapy programmes and these schools graduate approximately 200 students each year. Many students are also travelling to study music therapy in western countries to obtain advanced degrees; and a number of students were in attendance at the conference to learn from international delegates and their areas of specialty and research. To date, music therapy professionals from around the globe have made important contributions to the growth of the profession in China.

The conference offered a number of keynote sessions, alongside a full programme of concurrent papers and posters, as well as workshop opportunities post-conference. To see the full programme, please visit http://iammchina.org Concurrent sessions were conveniently organised into thematic opportunities for learning. These

Photograph 1: Amy Clements-Cortes GIM workshop attendees

included: oncology/palliative care/pain management, older adults, maternity/infant/paediatric, research, mental health, general hospital, special education, neurorehabilitation, music and health, programme development, and multi-culture. One example of a session in the neurorehabilitation theme which helps to elevate the significant impact that music therapy has, was given by Wendy Magee, titled *Music Therapy Assessment Tool for Awareness in Disorders of Consciousness (MATADOC): A Standardized Diagnostic Music-Based Measure for Minimally Responsive Populations.* This presentation outlined the MATADOC tool which has already been standardised for use in the diagnosis and treatment planning for adults with prolonged disorders of consciousness (PDOC) (Magee et al. 2014, 2016). Additionally, results from a pilot study assessing the use of the MATADOC tool for children with PDOC suggested that the tool was useful in helping with behavioural assessment and treatment planning for this population for which no standardised assessments currently exist (Magee et al. 2015). This is a substantial contribution to the field of music medicine and music therapy as the tool is used by the interdisciplinary team and highlights the important role music plays in assessment, diagnosis and treatment.

Another concurrent paper session provided by the new President of IAMM, Patravoot Vatanasapt, focused on how music can reinforce medical education. In his talk, Vatanasapt discussed the common qualities of music and medicine, and presented how music listening, music and movement and music making can be applied in medical education.

Keynotes addresses were given by: Alex Doman: *Healing at the Speed of Sound: Transforming Lives Through Music*; Tian Gao: *When Music Meets Trauma*; Suzanne Hanser: *Integrative Health Through Music Therapy: Accompanying the Journey from Illness to Wellness*; Brian Schreck: *Sounds of Life: Using Internal Sounds to Connect with the External World*; Cheryl Dileo: *Songs and Meaning-Making in Music Therapy at the End of Life*; and Tong Zhang: *Combining Medicine with Art – Effect of Music Therapy on Neurological Disorders.* While all of the keynotes were informative and well-delivered, the one that stood out for me was presented by Brian Schreck. In his moving talk, Schreck shared how he developed a music therapy intervention that records internal sounds of patients such as their heartbeat and lungs. In his clinical work this service is offered to various patients; for example, it is offered to expectant mothers whose babies will have incurable diagnoses. It is also offered to persons in paediatric palliative care, neonatal, cardiac and paediatric intensive care; and is actively used well into the bereavement process. These recordings can become so important to families when their loved ones pass away. It is through this innovative thinking, creation and embracement of technology that music medicine and music therapy work are joined to have a positive lasting benefit to patients and their families.

Photograph 2: Amy Clements-Cortés presenting at the 2016 IAMM conference

I was pleased to share my research posters on *Singing for Health and Wellness*, and *Rhythmic Sensory Stimulation and Alzheimer's Disease.* Further, I enjoyed presenting a concurrent paper on *Clinical Benefits of Singing for Cognitively Impaired Older Adults*, (Clements-Cortés, 2015a, 2015b) and

Photograph 3: 2016 IAMM delegates

providing a post-conference workshop on *An Overview of the Bonny Method of Guided Imagery and Music.* I was fortunate to have two amazing translators assigned to my talks, and to share my work with many professionals and students.

In addition to all these wonderful education opportunities, there were several social events and dynamic presentations of music, including a wonderful jazz concert, where attendees were invited to dance and sing with the performers. Congratulations to IAMM for hosting this conference in collaboration with Tian Gao and his conference organising team directed by Jing-Wen Zhang, Bing Li, the members of IAMM's Board of Directors, and the scientific committee. Start preparing your travel plans for the 5thinternational IAMM conference in June 2018 in Barcelona, Spain.

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Conference report

The 10th European Music Therapy Conference

'A symphony of dialogues'

Hiroko Miyake

The 10th European Music Therapy Conference
'A symphony of dialogues'

5-9 July 2016

University of Music and Performing Arts
Vienna, Austria

Hiroko Miyake, PhD, works as a music therapist and a community musician in Tokyo, Japan. She is a part-time lecturer at Meijigakuin University and a project staff member of Tokyo Diversion Research. Her main research interest focuses on how music can facilitate the co-presence of people who experience differences in terms of, for example, their body, values, experience and social standing.

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The 10th European Music Therapy Conference was held from the 5th to 9th of July 2016 at the University of Music and Performing Arts in Vienna, Austria. The overall theme of the conference was 'A Symphony of Dialogues'. As a non-European participant and coming from Japan, I found this theme to be an extremely interesting one. This is because experiencing the cultural differences and commonalities conveyed in the meaning of the word 'diversity' in music therapy was similar to the experience of 'having a dialogue'. In this report, I present an overview of the conference and some reflections particularly with regard to the dialogue session on music therapy and economy, and my oral presentation.

OPENING CEREMONY

This conference attracted participants from more than 80 countries around the world. In the opening ceremony, the moderator mentioned each of the names of the countries that were participating; the national flag and a welcome message in that country's language were then displayed in a slide presentation. The audience applauded and cheered for each one. The moment when the UK was mentioned was among the most impressive as it was immediately after the UK's referendum to exit the European Union. When the moderator said, "Welcome to Europe!" a great cheer went up from the audience and the venue was wrapped in applause. In that moment, several questions came to my mind, such as what does 'Europe' mean in this current society, and who is included and who is excluded? What does it mean to 'dialogue' in a diverse society?

After that, there was a lecture by Christian Gold. His lecture was entitled 'Triangular Objects in Music Therapy Practice, Theory and Research' (Photograph 1). It was a humorous talk on triangulation in music therapy using the analogy of

Photograph 1: Christian Gold's opening lecture

a triangle as a musical instrument. He observed how the vast majority of the oral presentations given at this European conference were describing qualitative, theoretical and clinical research. There were also several presentations based on case studies that used quantitative research although less than 1 per cent of the total used randomised controlled trials (RCTs). In such a situation, what role does the RCT play in music therapy research? He answered this question by using a parody which was based on an Austrian folk song. This song talks of the single chance in a long symphony to play the necessary sound, being the sorrow and pride of the triangle player of the orchestra. While listening to this lecture, I was thinking of the roles of qualitative and quantitative research in music therapy. Beyond the division of roles, what kind of dialogue is necessary to take advantage of these two worldviews?

DIALOGUE SESSIONS

In addition to the traditional oral presentations, poster presentations and workshops, a number of new genres were employed in the conference. These included documentary films about music therapy and related fields, as well as poster presentations using animation.

DIALOGUE SESSIONS

Among the different presentation genres, an important feature was the following four Dialogue Sessions that were held instead of traditional keynote speeches:

1) Music therapy and neuroscience;
2) Improvising and composing;
3) Music therapy and economy;
4) Dialogues on European music therapy professional development: Various practices, one goal.

In terms of the format of these sessions, two presenters would initially come to the stage: a music therapist and an expert in another field. Each of them presented their views on the given subject, and then they held an open discussion where audience members could also participate. I think this was an excellent structure as each theme was captured in a multi-faceted manner.

All four dialogue sessions of the 10th European Music Therapy Conference are available on demand through this link: http://www.mdw.ac.at/mdwMediathek/EMTC-2016/

From among these sessions, I would like to focus on 'Dialogue session III: Music therapy and economy' presented by Christian Köck and Brynjulf Stige. I think this is an important topic that relates to the entire music therapy profession, that is, the practice and research of music therapy and its benefits for the current society.

Köck's lecture, 'Changing health care in a time of austerity' (Köck 2016), was presented from the standpoint of health economics. According to him, since the beginning of the economic crisis in 2008 it has become more difficult – with regard to the public finances of developed countries – to maintain a system where all people have equal access to health care. As such, music therapy is facing a challenging situation. Köck emphasised that in order for the music therapy field to receive a share of public funds, it will be necessary to engage with both policy and politics. This means that it is important not only to analyse the results and economic effects of music therapy but to engage in public education. Köck argued that music therapists have a chance to change the dynamics of health care discussions by establishing alternative ways of solidarity in music therapy.

Stige's lecture was entitled 'Creating posts for music therapists within the changing realities of contemporary health care systems, how are these related to theory, research, and ethics?' (Stige 2016). He talked from the standpoint of a music therapist with a strong interest in social inclusion. According to him, the literature on the development of music therapy as a new profession focuses to a large degree on how individual therapists manage

to negotiate their ways to fit into a specific institution, such as hospitals, schools, facilities for the elderly or people with disabilities and so on. There seems to be a narrative of steady and linear progress of the music therapy profession that if only our practice and research continue to be better, music therapy will eventually become more socially recognised. However, now that the health care system is changing, the question of 'why music therapy?' has to be related with social justice. The reason is that funding sources are always limited and priorities are not only technical but also political issues. In this sense, is the empowerment of service users compatible with market-oriented health care services? In other words, if music therapy has to be part of current market-oriented health care services, is it really possible to empower the service users who are socially disadvantaged?

To answer this question, Stige introduced a project called 'POLYFON knowledge cluster for music therapy' (GAMUT 2015) that is currently being developed in Norway. In this project, different stakeholders such as researchers, service providers, practitioners, and service users come together to explore the role of music therapy in hospitals and community services. Stige used an analogy of a bicycle, saying that if you cycle hands-free, you have to be particularly sensitive to the conditions of the road. Likewise, to create posts for music therapy we have to collaborate according to the circumstances surrounding us.

Hearing this dialogue session, I thought of the social and political issues that the music therapy profession is facing in Europe, such as the economic crisis and immigration problems. In Japan, however, the profession is surrounded by different social and political issues. For example, music therapy has no national certification and has been socially unrecognised. So, there is a strong tendency to demonstrate the scientific evidence of music therapy in order to have public recognition of music therapy. Both in Europe and Japan however, I believe, as Stige argued, it is necessary for us to create different contexts and concepts of music therapy through collaboration and dialogue, and not to wait for governmental bodies to 'recognise' us. I think that rather than talking in broad social terms, the starting point for change lies in our everyday practice as music therapists.

Photograph 2: Delegates at the end of the conference[1]

[1] This photograph is taken from the conference's online gallery: https://www.mdw.ac.at/mth/?PageId=3207

MY PRESENTATION

My oral presentation was entitled 'Building space for diversity: Creative music-making project in urban Japanese context' (Miyake 2016). Its purpose was to share a part of my ongoing research on community music therapy in Japan with music therapists from different cultures, and to acquire insights on similarities and dissimilarities. I introduced the case study of 'Shiba community house music-playing laboratory' (in Japanese, *Shiba-no-Ye Otoasobi Jikkenshithu*). This is a community space in the Tokyo urban area where I organise creative music making workshops for fostering ties within local communities. Anyone can freely participate regardless of age, nationality or whether or not the person has disabilities. Standing on an equal footing with participants as 'members of the laboratory' and having fun by 'discovering' and 'experimenting' with sounds are arguably more important than 'teaching' music.

In this case study, my research question focused on how we could facilitate music activities to meet the diversity of group members. In other words, to consider how the diversity of people participating might enrich the content of the music. To this end, I have been modifying the framework of participation in accordance with the situation and participants at the time. Such modification of the framework seems to be more helpful than making an overarching framework to include all people. An opportunity is thus created to modify a framework which makes use of participants' diverse ways of being, instead of deploying a previously prepared framework.

After the presentation, I received an intriguing question from the audience with regard to the meaning of the terms 'diversity' and 'diverse people within different cultures'. Paraphrasing the comment:

> "For Europeans, diversity refers to diversity of cultural backgrounds, origins and ethnicity, among others; however, in this presentation, diversity refers to differences in age, values, life experience, music experience and social standing. In both cases, is what comes to mind not different when hearing the word 'diversity'?"

Indeed, if we grasp the first meaning of the word 'diversity', that is, difference in cultural backgrounds, origins and ethnicity, we would see that this is the different situation between Europe and Japan. On the one hand, in Europe the challenges that emerge from people living together with different cultural backgrounds and ethnicities have been visible. On the other hand, in Japan people are believed to have the unity of ethnicity and cultural backgrounds compared with Europe. In fact, there is a large number of foreigners living and working in Japan but their presence has perhaps been less visible.

However, if we grasp the second meaning of the word 'diversity', that is, differences in age, values, experience, and social standing, we would see that this is a common issue in the two different cultures of Europe and Japan. The common issue is whether it is possible to create opportunities to interact with each other while the existing differences remain. Community music therapy can be particularly useful for this area of work.

REFLECTIONS

Overall, the conference gave me the opportunity to have dialogues and start reflexively thinking about the cultural differences and commonalities in music therapy in Europe and in Japan. The context of issues and problems that each music therapy community works with are different but what we have in common is the importance of initiating every possible form of music therapy through collaboration and dialogue in the increasingly diversified social situations. Throughout this conference, the theme – 'symphony of dialogues' – demonstrated the importance of dialogue while respecting the values of different cultures.

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APPROACHES

Conference report

Examining the utility of music interventions for children with learning disabilities

Beth Pickard

Examining the utility of music interventions for children with learning disabilities

28 November 2016

Royal Society of Medicine; Live Music Now
London, UK

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INTRODUCTION

This interdisciplinary conference between the Royal Society of Medicine and Live Music Now was the second of its kind, following the inaugural collaboration in November 2015 which explored the evidence base for working through the medium of music with older adults with neurological disorders. This year's conference focused on a similar methodological rigour but with a different participant group in mind. Practitioners, academics, medics and therapists met at the Royal Society of Medicine building in central London to examine the utility of music interventions for children with learning disabilities. This was a particularly exciting focus with potential for rich cross-modal discussions between educational practitioners, musicians, academics, music therapists, health practitioners and policy makers. By examining the current evidence base for the value and impact of music interventions for children with learning disabilities, the conference aimed to "facilitate communication between interested parties to encourage future research, especially by fostering methodological rigour" (The Royal Society of Medicine 2016).

SESSION 1 – FOCUS: VISUAL IMPAIRMENT, RETINOPATHY OF PREMATURITY, RETT SYNDROME, BATTEN DISEASE

The morning session was opened by Evan Dawson, Executive Director of Live Music Now, who welcomed delegates and presenters, recognising what he referred to as a "melting pot" of practitioners from diverse disciplines. Dawson

provided a context to the day with a brief history of Live Music Now and the profound and moving impact that work with this participant group in particular has upon its musicians. Dawson feels that there is potential to develop the arts in health movement further if clinicians, musicians and academics work together to capture the evidence base for this impactful practice. Delegates were encouraged to discuss collaborations and ideas for ways forward with Live Music Now representatives during the day, to begin conversations that may enable this development to progress.

The first presentation of the morning session, chaired by Evan Dawson and Amanda Watson, was given by Graham Welch of the University College London Institute of Education, entitled *'Visual Metaphors for Sound for Congenitally Blind Children'*. Welch provided a rich evidence base for the assertion that the experience and perception of music is indeed multi-sited in the brain (Brandt et al. 2012; Schlaug 2015), and how this might relate to a child who has a learning disability. It was proposed that musical processing may be less affected than cognitive development in some children with learning disabilities, and that there may be potential to nurture cross-modal benefits to music interventions and musical experiences.

The seminal research of Robert Walker (Walker 1981, 1985, 2007) was drawn from to explore the experience of music for children who are blind or have a visual impairment, and the potential for early blindness to lead to enhanced auditory perception (Wan et al. 2009). Anecdotal evidence was discussed as well as multiple empirical studies exploring compensation of visual deficit by relying on experience from other sensory domains (Cattaneo et al. 2008); such as perceptually enhanced auditory capacity (Röder et al. 2000) and conceptually developing conceptual networks (Röder & Rösler 2003). This was a very thorough introduction to the evidence base for exploring the musical experiences of children with learning disabilities and/or sensory impairments, and set a clear tone for the empirical rigour of the day. Delegates were directed to Welch's Research Gate webpage to read more about his ongoing research in this area: www.researchgate.net/profile/Graham_Welch

The next presentation in the morning session was given by Neurologic Music Therapist Rosie Axon of Chiltern Music Therapy. This presentation, entitled *'Researching the Musical Engagement of Infants with Retinopathy of Prematurity'*, reported upon ongoing Chiltern Music Therapy research in collaboration with the Amber Trust, the British Humane Association and the University of Roehampton. The diagnosis of retinopathy of prematurity was first explained; this comprised problems with the development of retinal blood vessels in babies born prematurely. Reference was made to the assertion that children with retinopathy of prematurity often have a strong interest in music (Ockelford 1988; Ockelford & Matawa 2009) as well as rich anecdotal evidence from parents and carers about an enhanced interest in everyday sounds.

The research project in question is in its second of five years, where music interventions for children with retinopathy of prematurity are being delivered and evaluated by Chiltern Music Therapy. The sample of participants was engaged through 'Bliss', a charity for babies born prematurely (Bliss 2016). The project has three key aims: to research musical development in children with retinopathy of prematurity; to raise awareness of the potential of music for this participant group; and to make freely available musical resources to encourage early musical intervention. An outline of the clinical work was presented, with the timescale and logistics of interventions and resources.

The Ethnographic Observation System was praised as a valuable tool for readily recording interactions on an accessible app (EthOS 2016), and the newly developed Sounds of Intent Early Years Framework was used to analyse the clinical material collected (Ockelford & Voyajolu 2015; Sounds of Intent in the Early Years 2016). This detailed framework, which was outlined further during Ockelford's keynote lecture, "explains how young children (aged 0-7) develop musically, and sets this out in a large circular framework. It gives ideas for activities suited to children at different stages of musical development, and provides a simple way of recording their achievements. SoI-EY is fully inclusive and is suitable for all children, irrespective of their abilities and needs" (Sounds of Intent in the Early Years 2016).

Clinical examples were shared of children engaging in playful interactions through music at levels two to five of the Early Years Sounds of Intent Framework. From the data collected to date, the musical development of children who were blind and those who were neurotypical were compared. Of the small sample of four blind children, two had musical development below their neurotypical peers, one was above their neurotypical peers and one was the same as their neurotypical peers. Although a small sample, these were interesting data to note and indicate that further research is needed to inform practice more fully in this field and better understand the musical development and

experiences of children with retinopathy or prematurity and/or other visual impairments. The outcomes of the work inspired the music therapists to continue to empower and enable parents to work musically with their children, and further resources are being developed by Chiltern Music Therapy to support this aim.

The next presentation, entitled *'Music Therapy with a Child with Rett Syndrome: Longitudinal Observations of Therapeutic Approaches and Adaptations'* was given by Simon Hackett, Arts Psychotherapist, Northumberland, Tyne and Wear NHS Foundation Trust and Cindy-Jo Morison, Principal Music Therapist, Northumberland, Tyne and Wear NHS Foundation Trust. This reflection on a piece of longitudinal clinical work aimed to answer the question, 'What does improvement look like in Rett syndrome?' As with other presentations, an overview of the Rett Syndrome diagnosis was presented to enable meaningful engagement from the interdisciplinary audience. The presentation focused on an individual case study, with significant contribution from the client's mother to inform the presentation from an additional perspective. The aims of the clinical work were to increase communication through socialisation and to maintain or develop function for the client.

The client's mother described the transformative impact of music and its capacity to reintroduce purposeful hand movement for her daughter; the music therapist particularly recognised the positive impact of song in enabling increased and sustained eye contact. Examples of music therapy practice were shared over the ten years of engagement: demonstrating mirroring, matching, choice making, eye contact, fine motor development and the development of the therapeutic relationship. Morison emphasised the centrality of waiting in working through music with this participant group, and shared a model demonstrating potential approaches to working musically relevant to each stage of Rett Syndrome. It was interesting to learn that the therapist's inputs were related to the phases of Rett Syndrome more closely than their potential outcomes. This led to the question, 'Should we be measuring inputs rather than outcomes?' This was a challenging question and may conflict with other established evaluation tools. However, it was recognised that in particular relation to this degenerative and often debilitating diagnosis, it may be more constructive to explore and focus upon the value and impact of specific inputs rather than repeatedly measuring potential outcomes; this was the recommendation for future research which closed this case study presentation.

The final presentation in this first session was presented by Neurologic Music Therapist Rebecca Atkinson of Chiltern Music Therapy, entitled *'Exploring the Role of Music to Enhance the Quality of Life in Children with Batten's Disease'*. This is a collaborative project between Chiltern Music Therapy, the University of Roehampton, Erasmus+, the Amber Trust, the Baily Thomas Charitable Fund and the Batten Disease Family Organisation.

Following on from Welch's earlier discussion of the way the brain responds in a complex and multi-sited way to music, a brief video of an fMRI scan of a participant listening to music was played to affirm this notion. Neurologic music therapy was introduced as the context to this piece of research (Thaut & Hoemberg 2016) and its particular relevance to the clinical work outlined.

An overview of the Batten Disease condition was presented, contributing to the delegates' increasing awareness of highly medical conditions and constructs. This condition was described as a progressive neuro-impairment, resulting in sensory impairment, loss of speech and swallowing, loss of cognitive function and epilepsy. A parent's voice was also central in this presentation, potentially due to the challenges of obtaining the participant's voice due to their impairments. The parent here referenced a strong preference in their child for music in relation to other interests (Von Tetzchner et al. 2013).

A three-year research project with twelve participants was discussed, with the Ethnographic Observation System (EthOS 2016) and the Sounds of Intent Early Years Framework (Sounds of Intent in the Early Years 2016) again used as accessible and appropriate tools for data collection and analysis. Four individual clinical examples were presented, demonstrating meaningful vocal responses, patterned sensory enhancement, retention of lyrical content and expression through singing and pace of speech regulated by tempo. It was demonstrated that the principles and methods of neurologic music therapy (Thaut & Hoemberg 2016) can be particularly pertinent when working in music with participants who have Batten Disease to transfer skills from music therapy to everyday life. The research project will continue for three further years with intentions of determining how children with Batten Disease respond to music; determining whether there is potential for early intervention with music; and with a hope to generate resources and materials to enable such musical engagement and intervention.

SESSION 2 – FOCUS: AUTISM AND MUSICIANS IN HOSPITALS

After an opportunity to network and discuss ideas with delegates from diverse and interesting modalities over the coffee break, the second session commenced, chaired by Karen Irwin, Strategic Director of Live Music Now and Christos Sideras, Psychiatrist and Council Member, Psychiatry Section, Royal Society of Medicine. The first presentation, entitled *'How and Why is Music Beneficial for Individuals with Autism?'* was given by Pamela Heaton, Professor of Psychology, Goldsmiths, University of London. A similar diagnostic overview preceded the main presentation with clarification of DSM-5 criteria for Autism diagnosis (American Psychiatric Association 2013). The global median of 62:10,000 was presented (Elsabbagh et al. 2012), but the potential for this diminished statistic to relate to the change in diagnostic criteria was recognised. The variability in presentation of autism is further recognised in DSM-5 and was emphasised by Heaton, as well as the range of intellectual ability or learning disability experienced by those who have autism.

The well-known 'island of ability' seen in those who have autism and are recognised as savants was discussed, and a statistic presented from Mottron et al. (2013) who suggest that 45% of those who have autism have such a specialist interest, which is often music related.

Interestingly, of Kanner's (1943) original eleven participants, he noted that six demonstrated what he termed "unusual musical behaviour". A preoccupation with music is indeed widely reported in individuals who have autism (Simpson & Keen 2011). Heaton went on to discuss her own area of research, exploring the notion of 'spared processing of musical structure' in individuals who have autism (Heaton 2003; Heaton et al. 2007), as well as increased sensitivity to pitch and timbre in individuals with autism (Heaton 2009).

Heaton suggested that music processing and perception are often unaffected in the brains of those who have autism. Behavioural studies on music and emotion suggested that responses of those with autism were similar to their neurotypical peers (Heaton et al. 1999; Heaton et al. 2009). An interesting study was referenced (Allen et al. 2009) which explored the nature of the experience of music pertaining to individuals with high functioning autism, and exploited a wide range of purposes in social, cognitive and emotional domains. Further insight was gained by reflecting on the study of Sharda et al. (2014) who suggest that frontal temporal connectivity is disrupted in those with autism during spoken word but not during music. This meant that the brain of an individual with autism *could* be identified during an fMRI scan when experiencing language but *not* when experiencing music. This provided much food for thought to the audience of practitioners, musicians and academics who engage verbally and musically with those who have autism.

A study which gave particular encouragement to the utility of musical interventions to individuals with autism was the work of Allen et al. (2013) where autonomic arousal was measured in response to music. There was no difference in the results between participants with autism and neurotypical participants. There was less linguistic description from participants with autism and alexythimia despite their high level of arousal. Following on from these findings, individuals with autism were enabled to utilise their intact ability to understand emotion *in music* to understand their own emotions. Musical resources were provided to encourage participants to match their own emotional state with an emotion they recognised in a musical stimulus. A question was posed from a delegate about research of responses to music in men and women with autism diagnoses; Heaton recognised that autism is underdiagnosed in women, and that this is certainly an area worthy of further research.

This fascinating session was particularly complementary to the presentations of clinical work earlier in the day, and emphasised well how academics, researchers, practitioners, therapists and educators may work together to draw from the most thorough and informed evidence base in music psychology as well as music therapy and education, in order to utilise music interventions most effectively. The final presentation in Session 2 was entitled *'Children in Hospitals: Musicians Speak'* and was co-presented by Rosalind Hawley, Professional Musician for Live Music Now and Georgina Aasgaard, cellist and music health practitioner. This was an additionally contrasting perspective, drawing not from a clinical music therapy perspective but from an arts in health and music performance perspective, informed by Costanza and Welch's (2004) work on the context for musical interventions in hospitals. Delegates were encouraged to imagine the hospital environment from the perspective of the child with a disability; an unknown sound environment, isolation, lack of auditory/visual stimulation, reduced opportunities for communication and interaction, and reduced opportunities for self-expression.

An example of a soundscape recorded on a hospital ward emphasised the potentially isolating sound world in which children with disabilities may find themselves when in hospital. The utility, impact and positive effect of musical intervention in this context was presented with some anecdotal examples to support the discussion. A beautiful extract showed playful engagement with toys and a musical soundscape distracting a young boy while potentially painful and distressing medical procedures were carried out. This emphasised the focus of the work on the wellbeing of the child as opposed to the sickness of the child.

Another example demonstrated that through the development of a toolkit of musical ideas and opportunities, many positive outcomes had been achieved by the Songbirds Project through LIME Music for Health (Music for Health, no date). These included reduction of heart rate, increase of oxygen saturation, increased eye contact and smiles, increased awareness of sound, recognition of vocal sounds as musical dialogue and physically reaching out and expressing a desire to communicate. An example of this work can be seen in the case study: *'Lydia's Story'* at the following address: www.youthmusic.org.uk/lydias-story (Youth Music 2016). In these examples of practice, musicians came to be seen as a valid provision for supporting children in the hospital environment and were called upon to provide appropriate and valuable opportunities; music enabled families and medical staff to understand the children's mood and communication styles. There was a distinct emphasis on the social model of disability in this presentation, recognising that although children are unwell they are still children first and foremost and should not be defined by their diagnoses. A social model perspective of disability informed by Thomas (2013) is concisely summarised by Conn (2016: 11):

> "The social model of disability puts forward the idea that a person's disability can be located within their experience of social relations and the ways in which difference and diversity are accommodated and thought about within society (Thomas 2013)".

SESSION 3 – VIEWING OF POSTERS AND LIVE MUSIC NOW RECITAL

During the lunch break there was an opportunity to engage with and explore the poster presentations prepared for the conference. The breadth and quality of the posters reflected the diversity of delegates and presenters, and explored a range of themes including music therapy practice, music therapy services, music education, disability, software, resources, research, methods and more. Poster presentations are available to explore online via the following link: http://bit.ly/2lC1qUH and their focuses outlined in Table 1. Delegates also enjoyed a recital by Live Music Now harpist, Rachel Wick.

SESSION 4 – FOCUS: LEARNING DISABILITY AND THE NHS, A REVIEW OF METHODOLOGIES, AUTISM AND RETINOPATHY

The next session was chaired by Peter Freedman, Former President, Endocrinology and Diabetes Section, Royal Society of Medicine and Trustee, Live Music Now and Gordon Plant, Council Member, Clinical Neurosciences Section, Royal Society of Medicine. The first presentation was given by Dominic Slowie, National Clinical Advisor, Mortality and Learning Disability Director, NHS England, entitled *'Reducing Health Inequalities for Children with Learning Disability Through Participation'*. Slowie began by recognising the passion that was evident from the morning's presentation and his engagement with delegates over lunch.

To open the discussion, three examples were presented of the breadth of individual experience, learning and medical needs experienced by young people who have a label or diagnosis of 'learning disabilities'. This was a powerful reminder that the morning's sessions were highly specific (mostly individual) examples of practice; and that the field under examination could be far greater and more varied than we had discussed so far. An interesting question was put to the audience: "Are these young people *ill*?" Delegates concurred that learning disability did not equate with illness, but a rich discussion unfolded around diagnostic labels as tickets into services.

Learning disability was reflected upon as a construct, both as a medical diagnosis and as a protected characteristic. It was noted that the medicalisation of learning disability had led to many tragedies, with reference made to the scandal of Winterbourne View and the multi-agency response to this incident. A powerful statement was made by referring to antipsychotic medication as "chemical restraint", and the use of drugs to manipulate behaviour being an "ineffective and often inappropriate treatment". Slowie discussed a continuum between treatment and participation, and considered where music may play a part on

Poster title and presenter
Microanalysis of a non-directive music therapy session captures the moment of change Beth Pickard, Senior Lecturer, University of South Wales
Music and the brain: Review of recent evidence of music's role in neuroplasticity across the lifespan, implications for clinical interventions Victoria Lord, Clinical Neuroscience Researcher, University of Roehampton
Sounds of intent: Online measurement of musical development in children with complex needs Hayley Trower, Research Officer, University of Roehampton
A mixed-methods case study for primary-aged children, with and without learning difficulties, learning musical instruments for the first time Dawn Rose, Post-Doctoral Research Fellow, University of Hertfordshire
Music and attachment language development in infants Alistair Clarkson, Music Therapist, Living with Harmony
Music therapy at Chelsea and Westminster: Engaging in research and developing practice Claire Flower, PhD, Chelsea and Westminster Hospital NHS Foundation Trust
Music therapy empowering young children with autism and their families: Reporting back from the largest non-pharmacological randomised control trial in autism Grace Watts, Chelsea and Westminster Hospital NHS Foundation Trust
Lomakatsi's creative rehabilitation Igor Tojcic, Founder and Director, Lomakatsi
Cost-effectiveness analysis of a randomised controlled trial of improvisational music therapy's effectiveness for young children with autism (TIME-A) in the UK A-La Park, Assistant Professor, Health Economics Personal Social Services Research Unit
Evaluating social and musical outcomes of music lessons in children with low functioning autistic spectrum disorder Christopher Blake, Goldsmiths, University of London
ADHD and music: An exploration Eva Wilde, UCL Institute of Education, University College London
Psychodynamic music therapy and the work in classroom practitioners working with children with complex needs in Belarus: A potential space Lisa Margetts, PhD student, University of Roehampton

Table 1: Authors and titles of poster presentations

this spectrum. This was a particularly accessible and relevant context to examining the utility of musical interventions for children with learning disabilities from a refreshingly social model perspective.

Statistics were presented about the mortality rates of individuals with learning disabilities in comparison with the general population, as well as other health-related statistics – e.g. BMI over 30, premature death, with meaningful reference made to the 'Death by Indifference' campaign (Mencap 2007). Contemporary reference was also made to the recent developments in the screening process for Down's Syndrome in the NHS and the implications for the construct of learning disability in light of such medical advances (The NHS Rapid Project 2014). This contemporary context set the scene for a focus upon healthy inequality and the need to improve quality of life for those with learning disabilities, potentially through music interventions.

From the perspective of the NHS, there are increasing numbers of initiatives aiming to invest in health and wellbeing in a proactive and preventative capacity (NHS England, no date). As a core area of focus on the NHS agenda, all 44 Sustainability and Transformation Plans in the UK are being asked to consider the health and wellbeing of individuals with learning disabilities as a matter of priority. To arrive at the musical frame of the conference, Slowie referred to "participation as therapy", and gave examples of a multitude of community music and music therapy initiatives which have meaningful therapeutic outcomes for participants with learning disabilities; as well as his own insights from raising a child who has a learning disability and engages with music therapy.

It was suggested that *visibility* and *participation* are the two main determinants of a society's attitudes towards disability (Scior et al. 2015). This has meaningful connotations for examining the utility but also the context of music interventions for children and young people with learning disabilities. Slowie concluded by suggesting that more opportunities for musical participation would generate health as well as distraction from illness. He advised practitioners to capture valid, reliable evidence of the impact and cost effectiveness of their interventions, and to take advantage of this most fruitful time, in light of the NHS' current priorities in relation to learning disability, to build a more humane society.

The next presentation was given by keynote speaker, Adam Ockelford, entitled *'Gauging the Efficacy of Music Interventions in Children with Learning Disabilities: Towards a Common Framework'*. Ockelford began the session with two

key statements: firstly that music itself remains the under-researched "trumpeting elephant in the room" in the field of music-psychological research; and secondly that the dominant research paradigm of "asking people what they think about music" is often unavailable or inappropriate when working through the medium of music with children and young people with learning disabilities.

The dominant methodology of speaking about music requires language, metacognition, consistency of response and cognitive skills, which result in those with Severe Learning Disabilities (SLD) and Profound and Multiple Learning Disabilities (PMLD) often being marginalised from music psychology research. Reference was made to earlier presentations during the day which had already suggested that some participants with learning disabilities may experience and process music in similar or more advanced ways to their neurotypical peers. Ockelford, therefore, advocated that applied musicology may provide a methodology through which the musical experiences of those with SLD or PMLD could be explored and meaningfully researched.

Ockelford suggests that by analysing the musical experiences and responses of participants with learning disabilities in relation to a given musical stimulus, we can understand their methods of processing and understanding music. Here, the stimulus given and the response received may give some indication as to the way the stimulus was experienced, processed and interpreted. Although the child may not be able to articulate their understanding or experience of music, their music making itself may voice their level of understanding; demonstrating perception of pitch, recall of pitch, reproduction of pitch and comparing of multiple pitches. In the extract shared, a participant with autism who had little verbal language was able to demonstrate through musical play that she had an advanced understanding of the syntax of Western tonality and understood some of the humour of social interaction. This methodology is also closely linked to Ockelford's more advanced zygonic theory (Ockelford 2013).

In order to explore the rigour, validity and reliability of this methodology, Ockelford suggested that a number of *inputs* and a range of *outputs* are required. Through a statistical approach to the analysis of the body of musical data, underlying intentionality can subsequently be revealed. Another extract was shared of a participant with a degenerative, life-limiting condition, who played 64% of her musical outputs within twenty milliseconds of the beat. Ockelford understood this as affirmation that music was still part of this child's functioning and this enabled her to participate in a social and educational experience. The extensive Sounds of Intent work (Ockelford et al. 2005; Ockelford 2015) was shared to provide a contextual framework for exploring and analysing the musical responses and experiences of children with SLD/PMLD.

Each stage of the framework was explained and illuminated with examples from practice. This rigorous, deductive and inductive model underpinned much of the discussion during the day and goes a long way to respond to the demand for methodological rigour in examining the utility of music interventions for children with learning disabilities. Sounds of Intent was developed

> "to investigate and promote the musical development of children and young people with learning difficulties… This evidence should in turn enable those working with children with learning difficulties or autism both to offer more effective support in engaging with music as an activity in its own right, as well as better enabling them to use music as a scaffold to structure other learning and development" (Sounds of Intent, no date).

There are a vast range of open access resources available to practitioners via the Sounds of Intent website (www.soundsofintent.org).

The final presentation was contrasting to others in that it was co-presented by Marie Owen, Retired Consultant Paediatrician, formerly Gloucestershire Royal Hospital, Ockelford and Ashleigh, a young lady who has autism and retinopathy of prematurity. Owen shared her experience of being Ashleigh's doctor, and after a brief medical history, shared some insights into Ashleigh's continued engagement with music. It was a privilege to hear Ashleigh perform some of her favourite pieces on the keyboard, supported by her teacher, Ockelford.

Ashleigh performed with expression and technical ability as well as humour. She shared some Grieg repertoire that she enjoys as well as her favourite, Abba. Requests were also taken from delegates and Ashleigh responded to questions about her musical life. This was a valuable addition to have the voice of a musician with a learning disability at the centre of a prestigious, academic event.

SESSION 5 – PANEL DISCUSSION WITH ALL SPEAKERS

The final session of the day was a panel discussion involving all speakers from the day's proceedings.

Questions were welcomed from the floor, and are summarised in Table 2:

Summary of questions and answers
What's the point of 'non-live' music in a hospital environment? Live music can be responsive and thus adapted, this is not always so for recorded music. However there is potential and value to creating site-specific recordings for some hospital situations.
Is there evidence of what music works best with people with autism? There is evidence that the musical preferences of adults with autism are as varied as those of neurotypical adults. It is important to get to know the individual. Preferred music can have a positive effect on pain. In such cases it would be essential to know the individual's preferred music. There appears to be a critical period of music preference from ages 14-21, potentially related to hormones and strong emotions. It is often the music of that particular period of an individual's life which will be their favourite.
What are your thoughts on age-appropriateness of musical choices? It is the child's right to choose but the practitioner's responsibility to share a breadth of repertoire for the child to make an informed choice. An interesting way to broaden repertoire can be to introduce something wholly unfamiliar and unexpected to see if an interest may be peaked.
Should we teach those with autism to be musicians rather than to engage with a medical model – e.g. therapy? Learning music certainly has advantages for *all* children. There will be an event at Goldsmiths, University of London on 20th January 2017 specifically on teaching music to those with autism, entitled *'Sharing the Magic'*; it was acknowledged that there is certainly a gap in provision here. Opportunity is integral to this becoming a reality. Important that Music Hubs are aware of this and allocate funds accordingly.
Could Sounds of Intent link education, music therapy and arts in health practices? The panel agreed that today's presentation had certainly demonstrated that Sounds of Intent could be a valuable resource across disciplines.
What is the barrier to music making in hospitals and special schools? The PROMISE Report was referenced (Welch, Ockelford & Zimmermann 2001; Welch et al. 2016) which showed that 2% of special schools had a music therapist in 2000 while 20% of special schools had a music therapist in 2015, therefore progress is being made in acquiring musical provision. Ockelford suggested that it was everyone's responsibility to "bang the drum" to raise awareness of the need for musical provision.
Is there potential for ensemble work with children with learning disabilities? Yes, and there are examples of good practice here, however progression routes outside of clinical settings are often limited.
Do you feel it is important to involve health economists in this discussion? Yes, we need strong economic evidence. Health economists could be involved from the outset. There is an awareness that the 'gold standard' of tools for measuring impact in health economics are not relevant to autism/learning disabilities. We need to develop more sensitive tools to measure quality of life.
Is there still a place for approaches to music making like Montessori or Steiner? Ockelford stated that "no system is bigger than the child", and advocated that we all start with the child and explore their own learning needs. There are many benefits to these systems and also some transferrable qualities between them. Kodaly was also referenced as a useful system. The focus should be on the child regardless of the orientation or role of the practitioner.

Table 2: Summary of question and answers from panel discussion

Photograph 1: Panel discussion

REFLECTION

As a music therapist who has worked and researched in music with participants with learning disabilities, it was exciting to see such a rigorous and informed focus to this rich day of learning and sharing. Of particular note was the interdisciplinary dialogue during questions and breaks where doctors, academics, musicians, teachers, therapists, health economists, clinicians,

researchers and many more interested parties came together to learn from one another. The venue and host organisation also gave a sense of prestige to the occasion, recognising the potential of music as a valid intervention in this medical field; there were, however, some interesting, inherent medical model connotations to this affiliation. It was insightful to note the prevalence of clinical music therapy alongside applied musicology research and discussion around music education and arts in health interventions; there was a sense of acceptance and interest between disciplines and a recognition of the value of each distinct way of working.

From a disability perspective, it was interesting to note the highly medicalised terminology which often accompanied and articulated the rigorous research methods. This was not always aligned with the focus of the research which both recognised and highlighted the abilities as well as the impairments of participants with learning disabilities. This led me to wonder whether there is an evolving shift in research and practice to move away from a normative, deficit-based paradigm of disability (Straus 2014; Thomas 2013) to explore the rich and multifaceted experiences of participants with learning disabilities, both within and beyond music. Each presentation in its own way recognised music's potential to enable and empower participants with learning disabilities. It was encouraging to welcome a presenter who had a learning disability to share a performance of her work, and the words of parents were articulated and valued during multiple presentations.

Ockelford advocated several times for a "child-centred approach", recognising that while not one musical approach would accommodate or benefit all children with learning disabilities, there are potential developmental frameworks which can guide and inform the work in a meaningful and rigorous way. This valuing and celebrating of individual differences felt important in such a medical context and institution.

It was exciting to revisit Ockelford's work in a slightly different context, and to learn about diverse applications of his theories. The most refreshing session for me personally was that of Dominic Slowie, who spoke passionately about society's understanding of learning disability and how, at a systemic level, this will dictate engagement with and provision of music interventions for those with learning disabilities (Scior et al. 2015). It was exciting to note a practitioner in such a senior position discussing a social model interpretation of disability, and recognising the centrality of societal factors in the potentially disabling impacts of impairments (Barnes 2014; Burke 2012). I wonder whether the language of disability will continue to evolve, informed by Slowie and Scior et al.'s (2015) sentiments on visibility and participation shaping society's attitudes towards disability.

This day successfully wove together expert perspectives from diverse disciplines to create a highly informed examination of the utility of music interventions for children with learning disabilities, and provided many insightful ways forward, relating to practice, policy and attitudes to disability.

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Ανταπόκριση από συνέδριο

Ημερίδα του ΕΣΠΕΜ στο πλαίσιο της Ευρωπαϊκής Ημέρας Μουσικοθεραπείας

Ασπασία Φραγκούλη & Ουρανία Λιαρμακοπούλου

Ημερίδα του ΕΣΠΕΜ στα πλαίσια της
Ευρωπαϊκής Ημέρας Μουσικοθεραπείας

12 Νοεμβρίου 2016

Αθήνα, Ελλάδα

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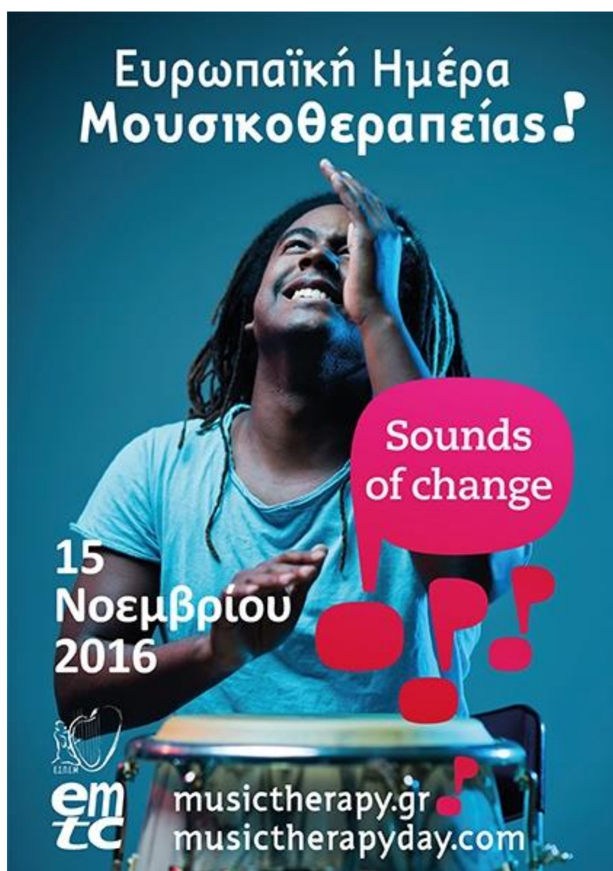
Ιστορικό δημοσίευσης: Υποβλήθηκε 27 Φεβρουαρίου 2016; Πρωτοδημοσιεύτηκε 10 Οκτωβρίου 2017.

Κάθε χρόνο, με αφορμή την Ευρωπαϊκή Ημέρα Μουσικοθεραπείας προτείνεται από την Πανευρωπαϊκή Συνομοσπονδία Μουσικοθεραπείας (EMTC, www.emtc-eu.com) ένα κεντρικό θέμα το οποίο πλαισιώνει τις εκδηλώσεις των διαφόρων εθνικών σωματείων μουσικοθεραπείας στην Ευρώπη που είναι και μέλη της EMTC. Το θέμα του κύκλου εκδηλώσεων της Ευρωπαϊκής Ημέρας Μουσικοθεραπείας «Ήχοι Αλλαγής» (Sounds of Change) για το 2016 ήταν και το κεντρικό μήνυμα της εκδήλωσης του ΕΣΠΕΜ (www.musictherapy.gr), μέλους της EMTC (Φωτογραφία 1).

Η εκδήλωση διεξήχθη στο Κέντρο Ημέρας για την ψυχολογική υποστήριξη ατόμων με καρκίνο (www.psychooncology.gr) το Σάββατο 12 Νοεμβρίου 2016. Η εκδήλωση ξεκίνησε με ομιλία από την Άντα Παΐζη (χοροκινητική θεραπεύτρια), η οποία παρουσίασε τις ποικίλες υπηρεσίες που προσφέρει το κέντρο ημέρας στους ασθενείς, στους οικείους τους καθώς και σε επαγγελματίες υγείας. Συγκεκριμένα, δήλωσε πως για τους ασθενείς προσφέρεται ψυχιατρική παρακολούθηση, ψυχοθεραπεία και συμβουλευτική, για τους οικείους τους προσφέρεται ψυχολογική υποστήριξη και συμβουλευτική, ενώ για τους επαγγελματίες υγείας



Φωτογραφία 1: Αφίσα της ημερίδας

προσφέρεται εκπαίδευση, συμβουλευτική και εποπτεία. Σημειώνεται ότι η Παΐζη πραγματοποίησε και μία σύντομη αναφορά στη χοροθεραπεία και τα οφέλη της. Η εκδήλωση υποστηρίχτηκε τεχνικά από τον ψυχίατρο του κέντρου ημέρας Χρυσόστομο Γιάκρα.

Στη συνέχεια έλαβε χώρα εισήγηση από την Ασπασία Φραγκούλη και την Ουρανία Λιαρμακοπούλου με θέμα «Εισαγωγή στη μουσικοθεραπεία» και κατόπιν πραγματοποιήθηκε βιωματικό εργαστήριο το οποίο επιμελήθηκαν η Χριστίνα Καλλιώδη, η Κάνδια Μπουζιώτη και η Χριστιάννα Αδαμοπούλου. Στόχος της εισήγησης αλλά και του βιωματικού εργαστηρίου ήταν η ενημέρωση του ακροατηρίου τόσο για το επιστημονικό πεδίο της μουσικοθεραπείας όσο και για τις προδιαγραφές των σπουδών μουσικοθεραπείας.

Κατά την εισήγηση της Φραγκούλη και της Λιαρμακοπούλου δόθηκε αρχικά ένας ορισμός της μουσικοθεραπείας και έγινε μια μικρή ιστορική αναδρομή. Συγκεκριμένα, αναφέρθηκε ο ορισμός του Παγκόσμιου Οργανισμού Μουσικοθεραπείας (World Federation of Music Therapy, 2011) σύμφωνα με τον οποίο η μουσικοθεραπεία χρησιμοποιεί τη μουσική για θεραπευτικούς σκοπούς και πάντα στο πλαίσιο μίας θεραπευτικής σχέσης μεταξύ ενός κατάλληλα εκπαιδευμένου μουσικοθεραπευτή και ενός ατόμου ή μιας ομάδας ατόμων. Επίσης, σημειώθηκε πως η αφετηρία της σύγχρονης μουσικοθεραπείας τοποθετείται στα νοσοκομεία των ΗΠΑ, όπου νοσηλεύονταν απόμαχοι του δεύτερου παγκόσμιου πολέμου.

Επίσης, δόθηκε έμφαση στον ρόλο της μουσικής μέσα στην μουσικοθεραπεία έτσι όπως ορίζεται από τον Bruscia (1998: 118)[1]:

> «Η μουσική είναι ένας ανθρώπινος θεσμός όπου ο άνθρωπος σχετίζεται και δημιουργεί νόημα και ομορφιά μέσω του ήχου, χρησιμοποιώντας τις τέχνες της σύνθεσης, του αυτοσχεδιασμού, της παράστασης και της ακρόασης».

Τονίστηκε ότι η μουσική στη μουσικοθεραπεία αφορά μια πολυεπίπεδη μουσική εμπειρία που περιλαμβάνει τη διαλογική σχέση μεταξύ των ατόμων που αυτοσχεδιάζουν (θεραπευτή και θεραπευόμενου) αλλά και τη σχέση τους με τη μουσική. Ο άνθρωπος, μέσω της μουσικής που παίζει, μπορεί να εκφράσει τα αισθήματα, τις σκέψεις και τις δράσεις του μια δεδομένη στιγμή, γεγονός που αναδεικνύει και η «Θεωρία της αναλογίας» (Theory of analogy) (Smeijsters 2005). Η συγκεκριμένη θεωρία υποστηρίζει ότι οι μουσικές διεργασίες του ατόμου είναι ανάλογες με τις ψυχικές διεργασίες που συντελούνται. Άρα, η μορφή της μουσικής έκφρασης ισοδυναμεί με την εσωτερική εμπειρία του ανθρώπου.

Στο πλαίσιο της συγκεκριμένης εισήγησης αναφέρθηκαν οι διαφορετικές μουσικοθεραπευτικές κατευθύνσεις που μπορεί να ακολουθούν αρχές της ψυχολογίας του βάθους ή των συμπεριφορικών, συστημικών, ανθρωποσοφικών και ανθρωπιστικών θεωριών, όπως παρουσιάστηκαν το 1998 στο συνέδριο των μουσικοθεραπευτών στο Kassel της Γερμανίας (Kasseler Thesenzur Musiktherapie, 1998). Ειδικότερα, επισημάνθηκε η ανάγκη διαφοροποίησης της μουσικοθεραπείας τόσο από τη χρήση της μουσικής στην ιατρική, όσο και από τις ψυχοθεραπείες και θεραπείες μέσω τέχνης που χρησιμοποιούν κατά περίπτωση και μουσική.

Στη συνέχεια της εισήγησης παρουσιάστηκε συνοπτικά η διαδραστική (interactive) και η δεκτική (receptive) μουσικοθεραπεία καθώς και αντίστοιχες μουσικοθεραπευτικές μέθοδοι. Στην πρώτη

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[1] Ελεύθερη μετάφραση ορισμού: "Music is the human institution in which individuals create meaning, beauty, and relationships through sound, using the arts of composition, improvisation, performance, and listening" (Bruscia 1998: 118).

προσέγγιση εφαρμόζεται ο κλινικός αυτοσχεδιασμός (clinical improvisation), η μουσική αναδημιουργία (recreation) και η σύνθεση (composition), ενώ στη δεύτερη η μέθοδος GIM (Guided Imagery and Music), η ρυθμιστική μουσικοθεραπεία (Regulative music therapy) (Schwabe 1987) και η μουσικοθεραπεία με ηχητικές δονήσεις (vibroacoustic music therapy) (Skille 1989; Wigram, Pedersen & Bonde 2002).

Επιπρόσθετα, στην ίδια εισήγηση δόθηκε ιδιαίτερη έμφαση στην παρουσίαση των προϋποθέσεων που συνιστούν ένα αποδεκτό πλαίσιο σπουδών μουσικοθεραπείας τόσο σε ευρωπαϊκό όσο και σε παγκόσμιο επίπεδο. Έγινε αναφορά σε ευρωπαϊκά προγράμματα σπουδών που περιλαμβάνουν είτε μεταπτυχιακές σπουδές (master) δύο ετών εξειδικευμένης κατάρτισης μετά από κύκλο πτυχιακών σπουδών (bachelor) σε σχετικά πεδία, είτε πτυχιακές σπουδές (bachelor) τριών-τεσσάρων ετών.

Στον επίλογο της παραπάνω εισήγησης έγινε αναφορά στον συνεχώς αναπτυσσόμενο τομέα της έρευνας όσον αφορά τη μουσικοθεραπεία τόσο με ποσοτικές όσο και με ποιοτικές μεθόδους με στόχο την αποτίμηση της θεραπευτικής διαδικασίας ή/και του αποτελέσματος. Επιπλέον, επισημάνθηκε η ολοένα αυξανόμενη τάση να πραγματοποιούνται έρευνες με την ποσοτική κυρίως μέθοδο. Οι ποσοτικές έρευνες επιβεβαιώνουν με μεγαλύτερη αμεσότητα την αποτελεσματικότητα της μουσικοθεραπείας κυρίως λόγω της δυνατότητας γενίκευσης των αποτελεσμάτων τους. Σε πολλές περιπτώσεις η έρευνα στη μουσικοθεραπεία αξιοποιεί τα αποτελέσματα ερευνών που γίνονται στο επιστημονικό πεδίο της μουσικής τεχνολογίας. Επιπλέον, διεπιστημονικές έρευνες πάνω στη χρήση μουσικής και τεχνολογίας μπορούν να προσφέρουν πολλά στον τομέα της μουσικοθεραπείας (Magee 2013).

Ένα τέτοιο παράδειγμα έρευνας στη μουσική και την τεχνολογία παρουσιάστηκε από την Λιαρμακοπούλου με την προβολή μέσω βίντεο (https://vimeo.com/143363985) του εγχειρήματος που πραγματοποιήθηκε στο διεπιστημονικό κέντρο για έρευνα στη μουσική και τους υπολογιστές στο Πλύμουθ της Αγγλίας (Interdisciplinary Center for computer music research, ICCMR, Plymouth University, UK). Στόχο είχε να δώσει τη δυνατότητα σε ασθενείς με σοβαρές κινητικές αναπηρίες να δημιουργήσουν μουσική.

Αναλυτικά, μέσω ενός προγράμματος στον υπολογιστή (Brain-Computer Music interface system, Miranda 2006), που δημιούργησε ο Joel Eaton δόθηκε η δυνατότητα σε τέσσερις ασθενείς με κινητικά προβλήματα να συνθέσουν σε πραγματικό χρόνο μουσική. Σημειώνεται ότι οι ασθενείς αυτοί ήταν μουσικοί πριν από την εκδήλωση της ασθένειάς τους. Το πρόγραμμα αυτό «μετέφραζε» την επιλογή συγκεκριμένων μουσικών μοτίβων μέσω της εγκεφαλικής δραστηριότητας των ασθενών και έστελνε τις επιλογές τους σε τέσσερις μουσικούς (κουαρτέτο εγχόρδων) οι οποίοι και ερμήνευαν τα μοτίβα αυτά σε πραγματικό χρόνο. Τη μουσική αυτή με τον τίτλο “Activating Memory” σχεδίασε και επέβλεψε ο συνθέτης Eduardo Reck Miranda. Ο σχεδιασμός του προγράμματος αυτού στον υπολογιστή έδωσε τη δυνατότητα της μουσικής αλληλεπίδρασης στους ασθενείς σε πραγματικό χρόνο.

Μετά την ολοκλήρωση της εισήγησης με θέμα: «Εισαγωγή στη μουσικοθεραπεία» που αναφέρεται παραπάνω, ακολούθησε συζήτηση και τέθηκαν ερωτήσεις από το κοινό. Αρκετές από τις ερωτήσεις αφορούσαν τις σπουδές μουσικοθεραπείας και ειδικότερα τα προγράμματα σπουδών μουσικοθεραπείας και τις προϋποθέσεις που χρειάζεται να πληρούν ώστε να προσφέρουν ένα επαρκές επίπεδο εκπαίδευσης, τόσο σε θεωρητικό όσο και σε πρακτικό επίπεδο. Επίσης τέθηκαν ερωτήσεις αναφορικά με τις γνώσεις μουσικής του υποψήφιου σπουδαστή μουσικοθεραπείας ως προαπαιτούμενο της έναρξης των σπουδών του. Γενικότερα, υπήρξε έντονο ενδιαφέρον για τη μουσικοθεραπεία ως μία εναλλακτική μορφή θεραπείας, η οποία δεν είναι ιδιαιτέρως γνωστή στο ελληνικό κοινό.

Στη συνέχεια ακολούθησε ένα βιωματικό εργαστήριο που συντονίστηκε από τις Καλλιώδη, Μπουζιώτη και Αδαμοπούλου και στο οποίο συμμετείχαν γύρω στα 25 άτομα (Φωτογραφία 2). Σύμφωνα και με το θέμα της εκδήλωσης –«Ήχοι Αλλαγής»– οι οργανωμένες μουσικές δραστηριότητες είχαν ως θέμα την έννοια της αλλαγής: πώς την αντιλαμβάνεται το άτομο και τι συναισθήματα του δημιουργεί σε ατομικό και ομαδικό επίπεδο. Κύριο εργαλείο της διερεύνησης ήταν ο κλινικός αυτοσχεδιασμός είτε με τη χρήση μουσικών οργάνων Orff, είτε με τη χρήση της φωνής, είτε μέσα από σωματικές κινήσεις. Οι συμμετέχοντες στο εργαστήριο έδειξαν ξεχωριστό ενθουσιασμό για κάθε μία μουσική δραστηριότητα, ο οποίος φάνηκε μέσα από τη δημιουργική έκφραση και το μοίρασμα σκέψεων και συναισθημάτων στο πλαίσιο της ομάδας. Μετά το πέρας του βιωματικού εργαστηρίου πολλοί από τους συμμετέχοντες παρέμειναν στον χώρο και συνέχισαν την ανταλαγή σκέψεων, συναισθημάτων και απόψεων, σχολιάζοντας θέματα των εισηγήσεων και συζητώντας με τους παρευρισκόμενους μουσικοθεραπευτές αποκο-

Φωτογραφία 2: Χώρος βιωματικού εργαστηρίου

μίζοντας περισσότερες πληροφορίες σχετικά με το πεδίο της μουσικοθεραπείας.

Ο αριθμός ατόμων που παρευρέθηκε στην ημερίδα του ΕΣΠΕΜ δηλώνει την επιθυμία και την ανάγκη του ελληνικού κοινού να ενημερωθεί για θέματα που αφορούν την προσέγγιση της μουσικοθεραπείας. Ευχόμαστε η επόμενη εκδήλωση του ΕΣΠΕΜ να προσελκύσει ακόμη μεγαλύτερο αριθμό συμμετεχόντων, ώστε να αποτελέσει μελλοντικά όχι μόνο μία ουσιαστική ευκαιρία για τη διάδοση της μουσικοθεραπείας, αλλά και αφορμή για μία γόνιμη συζήτηση σχετικά με το μέλλον της μουσικοθεραπείας στην Ελλάδα.

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Conference report

The First Music Therapy Research Day at Queen Margaret University, Edinburgh

Gillian O'Dempsey

The First Music Therapy Research Day

19 May 2017

Queen Margaret University
Edinburgh, Scotland

Queen Margaret University
EDINBURGH

Gillian O'Dempsey trained as a music therapist at Queen Margaret University, Edinburgh, qualifying in 2009. She worked for five years in the NHS Borders CAMHS service and taught the Introduction to Music Therapy module at Edinburgh Napier University. Since 2014 she has worked in the Child Development Service at Chelsea and Westminster Hospital NHS Foundation Trust and with children in mainstream primary schools. Gillian is a trustee of the British Association for Music Therapy.

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The First Music Therapy Research Day at Queen Margaret University, Edinburgh took place on 19 May 2017. Sponsored by The Centre for Applied Social Sciences at Queen Margaret University (QMU), the morning provided an introduction to the new PhD programme based at the university. In the afternoon, in collaboration with QMU, the Scottish Music Therapy Trust hosted a lecture given by American music therapist and researcher, Professor Barbara Wheeler.

Ian McMillan (Head of Division, Occupational Therapy and Arts Therapies, QMU) opened the day, welcoming the gathering of music therapists, music therapy students and researchers working both within Scotland and beyond. He celebrated this event, following on from QMU's hosting of the International Symposium for Music and Adolescents in 2016 (see e'Silva 2016), as a further step towards Philippa Derrington's vision of QMU as a hub for music therapy research and education in Scotland.

Photograph 1: Ian McMillan

WHY RESEARCH IN MUSIC THERAPY?

Giorgos Tsiris (Lecturer in Music Therapy, QMU) challenged his audience to offer possible answers to the question 'why research in music therapy?'. He suggested that there are three main narratives

in answering this question: advocacy, explanation and exploration. He cautioned against the first approach of advocacy, or the stance of "I know music therapy works, I just need to prove it" and also warned that there can be a 'discrepancy of assumption' where a music therapist wants to prove and a researcher wants to test the efficacy of an intervention.

Tsiris stressed the need for there to be research 'users, doers and leaders', emphasising that you "cannot become a doer unless you become a good user". In thinking about practising music therapists' engagement with research, he referenced a worldwide survey (Waldon & Wheeler 2017) which examined the extent to which music therapists view research as relevant to clinical practice. In the UK, results of the recent British Association for Music Therapy survey showed that only ten percent of music therapists consider that they undertake research as part of their employment (see Carr, Tsiris & Swijghuisen Reigersberg 2017).

Tsiris offered a memorable illustration of the metaphor of evidence as an iceberg, asking, 'if evidence is the tip of the iceberg, what is it like there?'. Is this pinnacle a place with stories of risk or danger, or a carefree environment? Continuing the metaphor, he suggested the need for a scuba diver to look underneath, at the iceberg, and see what is going on.

Of course, one of the risks of research is that the results might not be what had been anticipated, expected or hoped for. Tsiris suggested that negative outcomes can actually lead to an engagement with the research process and cited the example of the Matisse Trial in Art Therapy (see Hottum & Hewitt 2014). This is perhaps useful for the music therapy profession to bear in mind as the results of the TIME-A study (Geretsegger, Holck & Gold 2012) are made public.

WHY A PHD?

Having considered why we might undertake research in music therapy, the next speaker, Philippa Derrington (Senior Lecturer and Programme Leader, MSc Music Therapy, QMU) encouraged thinking about 'Why a PhD?'. Putting this within the context of music therapy training in the UK, she gave an overview of the history of the MSc Music Therapy programme at QMU since it began in 2002. Considering the introduction of a PhD programme as a milestone within the development of a training course, Derrington went on to give a brief survey of the other UK training courses and the development of PhD programmes.

Photograph 2: Giorgos Tsiris and Philippa Derrington

Using the image of a bug which keeps niggling and will not go away, Derrington described the impetus to start exploring PhD study and gave a broad introduction to the early planning stages. She emphasised the importance of talking with potential supervisors and linking with possible partner organisations or institutions (in her own PhD, Derrington collaborated with Anglia Ruskin University and the Institute of Education, London) as well as exploring potential funding opportunities. Listening to some of Derrington's own experiences it became clear that considerable preparation is needed before even embarking on PhD study. As a guide to this, Derrington provided an overview of what should be included in a research proposal and outlined the process for writing one. She acknowledged the PhD journey may change from what is set out at the start and the fact that there may be many surprises along the way!

WHY QMU?

Having started the day with a focus on music therapy research, the next two speakers widened the perspective and gave some insight into communities that potential PhD students would be joining at QMU. Lindsey Defew of the Graduate School set out to answer the question, 'Why QMU for your PhD?'. As she described what QMU offers PhD students, and some of the expectations on

them, it became clear that this is a setting with opportunities for regular, active engagement in a cross-faculty research community. Broadening the context further to the Scottish AHP research community, Judith Lane, Leader of the South East Scotland Hub of the Council for Allied Health Professions Research (CAHPR) and Senior Lecturer in Physiotherapy (QMU), gave a brief overview of the resources and support available through the local CAHPR hub and talked of recent developments including introducing webinars.

Photograph 3: Judith Lane

Photograph 4: Jane Burns

Having considered the wider context, the next speakers moved the focus in and shared their own experiences of undertaking doctoral study at QMU. Niamh Kinsella, an occupational therapist and current doctoral student at QMU, talked enthusiastically about the importance of the peer support she has found within the QMU research community and also of the valuable opportunities to present work, share ideas and attend conferences. Jane Burns, Lecturer in Art Therapy (QMU) looked back on her own experience of doctoral study and took us on an entertaining journey through 'SPACE', using this mnemonic to list elements of PhD research from the Spark of an idea, through People, Action, Curiosity ("you're becoming the expert so the more curious you are, the better your research") to the Endurance necessary to achieve the PhD goal.

MUSIC THERAPY RESEARCH: STRENGTHENING OUR MUSIC THERAPY PRACTICE

Barbara Wheeler (Professor Emeritus, Montclair State University) was guest lecturer for the afternoon. Warmly introduced by Melissa Humphreys, Chair of the Scottish Music Therapy Trust, Wheeler set out to give an overview of the evolution of music therapy research, using the three editions of her seminal text *'Music Therapy Research: Quantitative and Qualitative Perspectives'* (1995, 2005, 2016) as markers of some of the changes in research perspectives. Comparing the first edition with the recently published third edition, Wheeler noted a shift from considering qualitative/quantitative to objectivist/interpretivist paradigms, as well as an increase in combining these in mixed methods studies. She remarked on the growing awareness of the relationships between theory, practice and research demonstrated in the third edition and the wider range of international perspectives and approaches to research represented.

Photograph 5: Barbara Wheeler

Wheeler examined some definitions of research.

> "[…] a systematic, self-monitored inquiry which leads to discovery or new insight which, when documented and disseminated, contributes to or

modifies existing knowledge or practice" (Bruscia 1995: 21).

From Ken Bruscia's definition to Kate Gfeller's (1995: 29) more succinct line of "a disciplined or systematic enquiry", Wheeler gave an overview of the process of undertaking research which closely linked back to Derrington's talk in the morning. Highlighting the addition of chapters on methodological issues in the third edition, Wheeler expressed the prime concern as being the challenge of gathering, using and presenting information about music. She surveyed various methodological approaches, citing case examples of each. Included in this survey was the relatively new idea of arts-based research and Wheeler shared the example of Diane Austin's 'Grace Street' (Austin 2015, 2016), which uses the framework of a musical to express the lived experiences of men and women dealing with addiction.

It was fitting that amongst the examples Wheeler chose to illustrate various methodological approaches was Margaret Broad's phenomenological study of bereaved mothers' receptivity to music therapy following miscarriage or stillbirth (Broad 2014) as this originated from Broad's Masters dissertation, completed at QMU.

Identifying some possible areas for further development, Wheeler commented on the lack of ethnographic research in music therapy. She also observed that within the UK literature there are many examples of interpretivist case study research which are often not associated with a research methodology; she encouraged therapists to engage with research methodologies in their thinking and writing about their work and to access resources such as the free online journal, *'Qualitative Inquiries in Music Therapy'* (http://www.barcelonapublishers.com/Periodicals).

CONCLUDING

The final part of the day offered opportunity for informal discussion and reflection at a wine reception with live music performed by QMU music therapy students. The day had not only provided an introduction to the doctoral level opportunities for music therapists at QMU but challenged all attendees to broaden their thinking about what research is, and why we are doing it. Considering the definition of research as a disciplined or systematic enquiry (Gfeller 1995), the possibility is opened up that much of the information we gather in our day to day practice can be presented as research, if we rise to the challenge to engage with research methodology and frame our enquiries and findings accordingly.

These are exciting times for music therapy research in Scotland and beyond and I hope this event will be the first of many as QMU gains a growing reputation as a thriving centre of music therapy research.

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Conference report

International symposium
'Music therapy in educational settings'

Anne-Katrin Jordan & Philippa Derrington

International symposium
'Music therapy in educational settings'

5-6 May 2017

Institute for Musicology and Music Education,
University of Bremen, Germany

Dr Anne-Katrin Jordan studied educational science, musicology, and music therapy. She graduated with a PhD in empirical music education, and is currently working as a postdoctoral researcher (quantitative and mixed-methods in music therapy) and as a music therapist in child and adolescent psychiatry.

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Dr Philippa Derrington has been Senior Lecturer and Programme Leader of MSc Music Therapy at Queen Margaret University since 2013. She previously worked in schools in Cambridgeshire, England, and led a national 'Music Therapy for Youth at Risk' study, sponsored by The Music Therapy Charity.

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Publication history: Submitted 12 August 2017; First published 12 November 2017.

Although music therapy in educational settings is not a new subject it is still very topical. With the ratification of the UN convention and the change to an inclusive school system, the demand for support in schools is high. In countries such as Norway, music therapy has an established role in schools. But what is the state of research in this area? Is there evidence of the effects of music therapy in educational settings? What kind of research is needed in future?

These questions formed the starting point for this symposium, which took place on 5th and 6th May 2017 at the Institute for Musicology and Music Education at the University of Bremen, Germany (see photograph 1 for symposium delegates, and photograph 3 for an impression of Bremen).

Thanks to funding from the University of Bremen under the Federal Government's 'Excellence Initiative' scheme, Anne-Katrin Jordan was able to hold this symposium and thereby bring together an international and interdisciplinary team to discuss and plan further steps. The symposium was organised by an international research group: Eric Pfeifer (Freiburg, Germany), Thomas Stegemann (Vienna, Austria), Sandra Lutz Hochreutener (Zurich, Switzerland), and Anne-Katrin Jordan (Bremen, Germany).

Oral presentations, poster presentations, group work, as well as exchange and discussion, formed the core of the symposium. This report briefly highlights some key points.

Thomas Stegemann opened the symposium with a look at music therapy in educational settings from the point of view of a child and adolescent psychiatrist. He reported on a meta-analysis that revealed that one in every six children shows signs

Photograph 1: The symposium delegates

of emotional or behavioural disorders

Sandra Lutz Hochreutener explained the situation of music therapy in educational settings (pre-school, mainstream school, music school) in Switzerland. She listed the setting and, importantly, the need to find a 'safe place', as well as the atmosphere and interdisciplinary cooperation, as some of the challenges to the work. However, music therapy in schools offers the opportunity to work directly with pupils' inner conflicts that are somehow connected to the school, e.g. school anxiety.

Andreas Heye (Paderborn) gave a talk on the pros and cons of music therapy in educational institutions from a music psychology perspective. He generated discussion around the question of whether music therapy in schools should be described as psychotherapy and what kind of music therapy can or should take place in schools respectively.

Eric Pfeifer gave an overview of relevant meta-analysis and systematic reviews regarding the effects of music therapy for children and adolescents, followed by a summary of the current state of music therapy in Austrian schools. The first day of the symposium ended with group work where key findings were gathered and discussed.

Two presentations focusing on practical work kicked off the second day. Firstly, Ingeborg Nebelung (Horten, Norway) delivered an insight into the Norwegian practice of music therapy in schools. She presented examples of work with children with learning disabilities in special units that are affiliated to mainstream schools, and illustrated her talk, highlighting 'golden moments', with videos. Secondly, Karin Holzwarth (Hamburg, Germany) reported on many years' experience working at the music school in Hamburg and as a music therapist in schools. She discussed how this work, both in individual and group sessions, requires elements of depth and understanding of developmental psychology.

Referring to both these presentations, Anne-Katrin Jordan then presented a comparison study between music therapy sessions in a Norwegian and a German school. With the help of video analyses based on the AQR instrument (Assessing the Quality of Relationship), she demonstrated that similar music therapeutic methods (for example, the welcome song) involve different intentions and therefore require a differentiated view.

Philippa Derrington (Edinburgh, UK) introduced the development of music therapy in schools in the UK, with a focus on inclusion and results from a large study which involved interviews with adolescents with complex emotional and behavioural difficulties. The young people explained that the combination of playing and talking was important to them, and some even reported on noticing how their concentration in class felt easier after a music therapy session. Henrike Roisch (Munich, Germany) presented the violence-prevention project 'Drum Power' (in cooperation with Andreas Wölfl) by means of video extracts. Some reported effects from the programme included less aggression among young people, more positive social behaviour, and generally a better atmosphere in class.

As well as the talks, six posters were presented. Daniela Lechner (Vienna, Austria) and Ruth Diesing (Freiburg, Germany), two music therapy graduates, introduced the results from their master's dissertations. Both dissertations provided an overview of assessment instruments used in

music therapy in German-speaking regions from 2000 to 2016: one for children from birth to six years, and the other for adolescents aged 13 to 18. Claudia Vogel (Vienna, Austria) and Lisa Prechtl (Nuremberg, Germany) also presented results from their master's research project: Claudia Vogel gave on overview of music therapy in both special schools and music schools in Austria; Lisa Prechtl introduced her project 'Echt Stark' to help 11-year-old girls with low self-esteem. Yvonne Mäder, Sandra Lutz Hochreutener and Annkathrin Pöpel (Zurich, Switzerland) presented a poster focusing on music therapy and resilience. In this empirical study, pre-school children with migrant backgrounds showed significant changes in the field of social abilities or social competencies. Finally, Wolfgang Zaindl (Munster, Germany) provided an insight into the evaluation of an integrative music therapy programme for teachers.

Photograph 2: Workshop and discussion

A fruitful discussion amongst the delegates then followed (see photograph 2). They looked at aims, challenges (for example, the cooperation between music therapists and teachers in schools), strategies for implementation (for example, the importance of political work and public relations), definitions and future research studies; identifying recovery and joy as highlighted as central aims. Multi-centred studies and standardised assessment instruments as well as a needs analysis of children and teachers were discussed in terms of future collaborative research.

Overall, it was an inspiring symposium that also created healthy debate about music therapy in various educational settings. All papers will be published by the end of 2017 by Waxmann Publishing Co.

Photograph 3: The town musicians of Bremen

Suggested citation:

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APPROACHES

Conference report

15th World Congress of Music Therapy

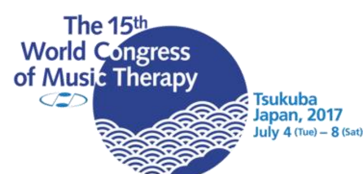
'Moving forward with music therapy – Inspiring the next generation'

Katie Boom

15th World Congress of Music Therapy
'Moving forward with music therapy – Inspiring the next generation'

4-8 July 2017

Tsukuba, Japan



Born and raised in the heart of Aotearoa New Zealand, **Katie Boom** is a registered music therapist now working at Raukatauri Music Therapy Centre in Auckland. She is currently working with young people with disabilities in both music therapy centre and school settings. She completed a Master of Music Therapy degree in 2017 at Victoria University of Wellington. Katie loves to dance, cook straight from her garden, renovate anything old, and she nearly always has a song in her head.

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INTRODUCTION

On 4 July 2017, the 15th World Congress of Music Therapy held its opening ceremony in the Tsukuba International Congress Centre, Tsukuba, Japan. Over the next five days, 2959 participants from 49 different nations (see Photograph 1) attended an incredibly wide range of 506 presentations. This impressive schedule was arranged by the organising committee from the Japanese Music Therapy Association, headed by Michiko Kato. The theme of the congress was *'Moving Forward with Music Therapy'*, with the sub-theme *'Inspiring the Next Generation'*.

PRE-CONGRESS SEMINARS

Prior to the official opening ceremony, delegates gathered to attend the pre-congress seminars on 4 July. These sessions included: a seminar presented by Sarah B. Johnson on developing clinical skills through neurologic music therapy concepts; a presentation by Sheri L. Robb on music therapy and palliative care in a paediatric cancer setting; a workshop on traditional Japanese drums, presented by Michiko Kato and Natsuko Yasujima. Kenji Tsuchino presented a seminar on Usagawa theory for children with developmental disabilities, while Naoko Moridaira and Issho Fujitsu presented on mindfulness-based music therapy, and Buddhist meditation. Music therapy students attended a student seminar, during which Amy Clements-Cortes and Katrina Skewes McFerran gave advice on transitioning from student to professional. Finally, Gary Ansdell presented a session on the way music helps in everyday life, and a team of presenters from the USA, headed by Joanne Loewy, presented on NICU music therapy training in rhythm, breath and lullaby.

Photograph 1: WCMT 2017 delegates gather on the stairs for a group photo (used with permission from the Japanese Music Therapy Association)

SPOTLIGHT SESSIONS

Spotlight session 1

Each morning the WCMT began with a spotlight session. These spotlight sessions focused on specific themes, beginning with music therapy and the wellbeing of older adults. This first session was moderated by Amy Clements-Cortes, President of the World Federation of Music Therapy. Hanne Mette Ridder from Denmark opened the exchange with a presentation on musical interaction and wellbeing in caregiving and dementia. She shared a moving case study, which explored the intricacies of music's role in enhancing a caregiving relationship, and revealed that carers tend to underestimate their competency in attuned musical interaction. Following this presentation, Imogen Clark spoke about Australia's healthy aging policies, and how they can be innovatively incorporated into music therapy with older adults with cardiovascular disease and dementia. Representing Japan in this spotlight session, Mayu Kondo discussed the state of care for older adults and outlined the trajectory of Japan towards an aging society. She also described current music therapy practice as it relates to older adults, which included working with groups in the community and working in hospitals and care centres. To round off the session, Karyn Stuart from South Africa presented a pilot study on therapeutic singing with caregivers in morning dementia care routines. She recommended further study into the training of caregivers in basic therapeutic musical skills, an approach which received some attention at this congress.

Spotlight session 2

The second spotlight session focused on music therapy and trauma work, and was moderated by Gene Ann Behrens. Elizabeth Coombes from the UK presented a project in Palestine, which centred on equipping local staff to engage in therapeutic music groups with children. She emphasised the capacity of music therapy to encourage the development of resilience and healthy coping strategies. From the USA, Barbara Else provided an illustration of the American Music Therapy Association's disaster response efforts, while Mireya Gonzalez from Chile outlined the music therapy method used in a burns rehabilitation

centre. Through using a variety of musical, artistic and movement-related activities to encourage creative expression, Gonzalez highlighted the importance of considering cultural aspects of music therapy in trauma work. Sanae Hori from Japan rounded off this spotlight session with a presentation on her experience of the 1995 Great Hanshin-Awaji Earthquake. Hori provided a personal account of experiencing trauma and relating to patients in palliative care.

Spotlight session 3

The third day of the congress opened with a spotlight session on music therapy research, with a specific focus on evidence and story. Melissa Mercadal-Brotons from Spain acted as moderator, and Hyun Ju Chong from Korea opened the session with a presentation of her research on keyboard playing and forearm rehabilitation. She outlined the study's research method and results, which were strongly evidence-based. Chong, however, affirmed the need for both evidence and story in music therapy research, and she noted the importance of music itself in reporting results. Jaakko Erkkilä from Finland then spoke about his research on working with people with anxiety and depression. He explored the potential of improvisation to provide a safe treatment, and asserted that structure was important in this improvisational technique, in terms of understanding models and methods. Finally, Katrina Skewes McFerran gave a resounding call for courageous music therapy researchers willing to conduct rigorous qualitative studies in their field. McFerran prefaced her speech with a spoken acknowledgement of her privileges that had led to her being able to present at the congress, and then devoted her presentation to critiquing and challenging the evidence-based model of research.

Spotlight session 4

The final spotlight session was on music therapy and cultural context, and was chaired by Annie Heiderscheit from the USA. Sunelle Fouché from South Africa drew on her experience as co-founder and executive director of MusicWorks, a non-profit organisation working in marginalised communities, to talk about the complexities of working in a culturally diverse context. She reflected that music therapists working in similar contexts should strive to value cultural differences while also keeping sight of a shared humanity and all the commonalities that attend that shared experience. Laura Beer from the USA spoke next, highlighting the importance of careful reflection around the use of music from other cultures. She shared some of her personal journey with music from cultures different to her own, and advocated for open conversation with music therapy students and practitioners from other cultures. Rika Ikuno-Yamamoto offered a Japanese perspective on music and culture, and noted the wide variety of different music used daily in modern Japanese life. She gave insight into the shifting landscape of musical forms in Japan over the last 200 years and spoke about the ability of music to mediate relationships. To conclude this session, Brynjulf Stige spoke about health as both a universal human right and a situated cultural practice. He recommended further debate around the pros and cons of the medical and social models of practice, and suggested 'health musicking' (noting that the Norwegian equivalent is one word) as a useful term in discussing this.

Each session concluded with time for questions in which the audience asked pertinent questions of the presenters. This space resulted in some interesting and less structured discussion of each topic. For example, there was a question during the last spotlight session about how to respectfully use instruments from another culture, which the panel answered with a recommendation to know the history and typical cultural function of the instrument before incorporating it into music therapy practice.

OVERALL PROGRAMME

After each spotlight session concluded in the morning, the delegates dispersed to an astonishing number of workshops, round table discussions, and paper presentations. I attended some extremely thoughtful and reflective sessions on community music therapy in different settings, and encountered a lot of discussion about training caregivers, family and other invested people in music therapy skills. There was little scheduled time to rest during the congress week, with a total of 506 presentations tightly scheduled in every available room and time slot. Due to this timetable, some attendees found they had to skip sessions to claim some reflection time. However, the breadth of topics covered was wide and at the end of each evening I felt freshly inspired and informed. As a new music therapist, I felt that the WCMT fulfilled its stated goal of inspiring the next generation, particularly through the student events and also

Photograph 2: Delegates gather for a lunchtime performance

the willingness of respected researchers and practitioners to engage with students and younger therapists on a personal level. Although each delegate's experience of the congress was very different due to the wide variety of presentations offered, I felt that the theme of 'moving forward with music therapy' was represented by discussion around challenging the evidence-based research model, engaging the wider community in music therapy training and practice, and a call to investigate all aspects of musical intervention, including the possibility of negative effects.

Photograph 3: Taiko drumming at a lunchtime performance

MUSICAL MOMENTS

In a busy schedule, live music provided welcome interludes. Among the musical components of the congress were the 12 lunchtime performances in the large open foyer at the heart of the conference centre (see Photograph 2). The music from these performances could be heard and witnessed while riding the numerous open escalators from floor to floor in the centre, and large groups of delegates gathered around the performance to see enthusiastic musicians playing Japanese taiko drums (see Photograph 3), crystal singing bowls, and even a theramin, as well as choirs, dancing groups and pop bands. Some of these performers were local musicians with disabilities – and with contagious energy.

A number of the sessions offered throughout the week were musical workshops, and I had the wonderful opportunity to be involved in leading hundreds of attendees in a song circle, with chant leaders Jodi Dunn and Barbara Winnwalker. This session was a highlight for me personally, as chant leaders from all around the world shared music from their cultures. This session also evolved into a concert held on Wednesday evening in the foyer

(see Photograph 4). Another highlight for me was attending the student jam session, in which music therapy students from Canada, Italy, Japan, France, Korea, USA, and Spain performed with voice, instrument and movement to a packed audience (standing room only). The atmosphere at this and other student events was energetic and infectiously supportive. Music also bookended the congress during the opening and closing ceremonies, as local musicians came on stage to share traditional Japanese performances with the assembly (see Photograph 5).

Photograph 4: Song leaders after a concert on Wednesday evening

Photograph 5: Japanese performer Tazae Mochizuki leads a Sanbaso performance at the opening ceremony

HIGHLIGHTS

Every morning, the stroll down a long tree-lined boulevard from the local train station to the conference centre (see Photograph 6) was filled with fellow music therapists in knots of conversation and laughter. As the week progressed, this daily pilgrimage became a highlight for me. A bystander would have witnessed many hugs, jokes, and thoughtful conversations along this boulevard during congress week, and this felt to me like a lovely organic expression of an international community coming together. In the same vein, the many informal gatherings and shared dinners at local restaurants were a highlight, as delegates shared affirmation and friendship. More structured highlights included the optional cultural programmes offered by the WCMT, such as a traditional tea ceremony, calligraphy class, and flower arrangement sessions.

Photograph 6: Music therapists on the walking street from the train station to the conference centre

On another note, there were several honours awarded to outstanding members of the international music therapy community, with Felicity Baker, Joanne Loewy, Alexia Quinn, and Jen Spivey as recipients. Notably, the esteemed Barbara Wheeler was awarded the WFMT Lifetime Achievement Award for 2017. A personal highlight for me was being selected at the closing ceremony to receive the Student Poster Award for my thesis research presentation. The 15th World Congress of Music Therapy closed (see Photograph 7) with the appointment of Melissa Mercadal-Brotons as the new President of the WFMT, and the announcement of South Africa as the host country for the 16th World Congress in 2020. Arigatō gozaimasu, Japan!

Photograph 7: Photograph 7: Congress organising committee members celebrate at the closing ceremony

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Tribute

A tribute to Mary Priestley

4 March 1925 – 11 June 2017

Kenneth Bruscia

Temple University, USA

I would like to pay tribute to Mary by sharing her human side, as I knew her. We met only once, but we developed a close friendship through the many letters we exchanged over a seven-year period.

Mary was warm and compassionate. I was always comfortable confiding in her about both personal and professional things, and her responses were always wise and supportive. She would either share an insight that would help me, or she would advise me on how to protect myself from harmful feelings. The most touching response was when my father died, and I told her that all of my nuclear family were gone. She quickly responded by offering to be my cousin. She said she couldn't be my sister because we lived too far away.

Mary was humble. It seemed she never realised how great her contribution to music therapy was. Perhaps this was because she did not receive the recognition she deserved, which I could never understand. She always seemed surprised by any compliment. She was so surprised and excited when I invited her to publish the Herdecke Lectures that she implored me: "Don't change your mind!"

Mary hated computers. The Herdecke Lectures were originally typed on paper. Thus, to prepare them for the book she had to enter the text into computer files. She complained a lot about that, and when she finished the book, she proudly proclaimed that she had conquered the dragon.

A theme throughout her letters, especially in the later years, was her desire to be more active. She often felt alone and bored doing nothing. She wanted to continue working with clients, playing in ensembles, giving lectures, teaching, and any other professional activity related to music or music therapy.

As Mary confronted the inactivity of retirement, she became very fascinated with being in a "void". Mary sent me a paper she presented in 1991 entitled, *'Trusting the Fertility of the Void'*. I don't believe it was published anywhere. In it she explored how emptiness is experienced in daily life, creativity, healing, and disappointment, and how these times provide opportunity for new and more fulfilling ways of being. Most important is an awareness of the possibilities provided by what might already be in the void without awareness, as well as what is not there.

Mary dealt with the voids in her everyday life as a retiree through creative activities. She loved to paint when her days felt empty. I do not know if she saved any of her paintings, but I would relish having one as a remembrance of her. Mary also took pleasure in writing limericks. In 2001, she sent me a complete book of them with her own illustrations of each. Here are two that show her great sense of humour.

A vague man who lived near to a river
Struck a close bond with his liver
He never went yellow
That quaint, quirky fellow
And thoughts about gin made him quiver!

A sensitive young girl called Lily
Was an honest and brave little filly
She said "I won't vex
My partner with sex"
But he thought she was just rather silly.

Mary's orientation to therapy was much broader than Freudian thinking. She was very interested in Jung, body work, and various Eastern philosophies.

Probably more than is realised, Mary thought in terms of how soma, psyche, and spirit were integrated. She practised and taught the Chi-Kung six swimming dragon exercises. These exercises were concerned with combining "Taoist breathing practices with the circulation of 'Chi' (the vital force) along the acupuncture meridians" (Priestley, n.d.).

Mary spoke freely about her own physical states and conditions and how they were connected to higher layers of consciousness. In her article on the void, she described an exercise she did from ancient 5th veda. After eating, she sat still for five minutes and then walked around to facilitate digestion:

> As I sat I could hear my abdomen beginning to make happy and active noises, and then, surprisingly, I felt my digestion as a part of the great activity of nature — inside me and outside, and realised forcibly that it was something that I did not consciously have to do but just humbly and respectfully allow to happen (Priestley 1991: 5).

She was always gracious with those who were interested in her work. She was not concerned about how accurately others understood or interpreted her work, and she did not impose her ideas and techniques on her students. She was also not concerned with ownership of her ideas or whether her work had been cited by others.

As evidence of her openness and generosity, Mary donated all her clinical materials to Temple University to establish an archive of Analytical Music Therapy in its library. Completed in 2002, the archive contains all her personal/clinical diaries from 1971 through 1990, 82 cassette and 27 reel-to-reel tapes of her improvisations with clients, and all her known published writings. The archive provides clinical data on her work with 104 clients. Before sending these materials, Mary carefully went through each material and removed all identifying data of her clients.

Mary made an indelible mark on my life, not because she was such an important pioneer in music therapy, but because of the kind, loving and creative woman she was. Mary demonstrated these personal qualities to me in her letters, but all one need do is to listen to her improvise with her clients. Her music is immediately responsive, understanding, and supportive, with splashes of boldness and her indomitable personality. We have lost a beautiful human being, and fortunately for us, she devoted her being to music and music therapy.

Here is the last part of a poem that one of her clients wrote at the end of their work together. It appears in *Essays on Analytical Music Therapy* (pp. 317-318). It describes Mary much better than I have.

BIRTHDAY GIFT

…

You came into my life —
Unwanted.
You made me feel pain —
Unforeseen.
You taught me that people
Are human — and precious.

You continue to affirm me
As a loving — and lovable person.

You have opened my eyes
To the joy of sharing —
And the pain and sorrows
Of loneliness
You have created for me
Beautiful silences,
Downy-lined, like a bird's nest.

You have supported me
In hours of darkness,
Strengthened me
In moments of weakness,
Encouraged me to live
When I wanted to die,
Tended my wounds
And lanced my boils.
Shown no revulsion
At my shameful deeds.

You have accepted me
As I am,
Tried always to understand
And given me courage
On this dark voyage
Of self-discovery.

Now, as the time nears
For us to part,
When I may never
See you again,
In my innermost heart,
My secret, inviolable sanctuary,
Seated at ease there,
I find you.

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Translated abstracts
Μεταφρασμένες περιλήψεις

Μετάφραση στα ελληνικά: Δήμητρα Παπασταύρου

Εφαρμόζοντας το «East Kent Outcomes System» (EKOS) στη μουσικοθεραπεία

Rhian Saville

ΠΕΡΙΛΗΨΗ

Το παρόν άρθρο εξετάζει τις τρέχουσες προσδοκίες σχετικά με τη μέτρηση κλινικών αποτελεσμάτων στο σύστημα υγείας του Ηνωμένου Βασιλείου, και εισάγει μια εφαρμογή του East Kent Outcomes System (EKOS) (Johnson & Elias 2010) ως μέσου μέτρησης της κλινικής αποτελεσματικότητας της μουσικοθεραπείας. Σκοπός του άρθρου είναι να περιγράψει τον τρόπο εφαρμογής του EKOS στο κέντρο φροντίδας Nottinghamshire Healthcare NHS Foundation Trust, και να παρουσιάσει τη χρήση του στη μουσικοθεραπευτική πρακτική. Η εφαρμογή του EKOS επεξηγείται μέσα από μια μελέτη περίπτωσης με ένα πελάτη της Υπηρεσίας Ατόμων με Νοητική Υστέρηση του κέντρου. Παρατίθενται παραδείγματα για τον τρόπο πιθανής χρήσης των δεδομένων που συλλέγονται για την περιγραφή της αποτελεσματικότητας της μουσικοθεραπείας. Ταυτόχρονα, αναφέρονται οι συνέπειες για τη μελλοντική χρήση του EKOS στον επαγγελματικό χώρο της μουσικοθεραπείας.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

μουσικοθεραπεία, αποτελέσματα, αποτίμηση, κλινική αποτελεσματικότητα, αξιολόγηση και θεραπεία, EKOS

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Χαρτογραφώντας την ψυχική ανθεκτικότητα: Αναλύσεις μέτρων αξιολόγησης και προτεινόμενες χρήσεις στη μουσικοθεραπεία

Βαρβάρα Πασιαλή, Laree Schoolmeesters & Rebecca Engen

ΠΕΡΙΛΗΨΗ

Η ψυχική ανθεκτικότητα [resilience] –η οποία αποτελεί μια διαδικασία και μια ικανότητα προσαρμογής στις δυσμενείς συνθήκες ζωής ή στο άγχος που συσσωρεύεται– φαίνεται να είναι ιδιαίτερα σημαντική για τους μουσικοθεραπευτές. Ωστόσο, κατά την αξιολόγηση της ψυχικής ανθεκτικότητας παρουσιάζονται διάφορες προκλήσεις. Ελέγξαμε μια σειρά από πηγές (n = 307) και προσδιορίσαμε επτά κλίμακες που παρέχουν ποσοτική μέτρηση του βαθμού ανθεκτικότητας: την κλίμακα ανθεκτικότητας Connor-Davidson (Connor-Davidson Resilience Scale; CD-RISC), την κλίμακα για τη μέτρηση της ανθεκτικότητας παιδιών και νέων (Child and Youth Resilience Measure; CYRM), την κλίμακα Devereux για την αξιολόγηση της νηπιακής ηλικίας (Devereux Early Childhood Assessment; DECA), την κλίμακα για την προδιάθεση στην ανθεκτικότητα (Dispositional Resilience Scale; DRS), την κλίμακα ανθεκτικότητας (Resilience Scale; RS), την κλίμακα ανθεκτικότητας για ενήλικες (Resilience Scale for Adults; RSA) και την κλίμακα ανθεκτικότητας για εφήβους (Resilience Scale for Adolescents; READ). Εξετάσαμε κάθε κλίμακα, εντοπίσαμε τις κυριότερες ψυχομετρικές ιδιότητες και καταλήξαμε σε συμπεράσματα σχετικά με τις πρακτικές χρήσεις τους στη μουσικοθεραπεία (την ανίχνευση [screening], τη σκιαγράφηση ενός προφίλ για την οργάνωση σχετικών παρεμβάσεων και τη μέτρηση των αποτελεσμάτων της θεραπείας). Οι μουσικοθεραπευτές πασχίζουν να προωθήσουν την ευημερία των πελατών τους, και τα μέσα μέτρησης της ψυχικής ανθεκτικότητας μπορούν να παρέχουν έναν τρόπο αξιολόγησης, έναν τρόπο σκιαγράφησης ενός προφίλ με στόχο την παρέμβαση ή έναν τρόπο εγκαθίδρυσης συγκεκριμένων ερευνητικών πρωτοκόλλων που εστιάζουν στις ικανότητες που βασίζονται στην αντοχή. Αυτά τα μέτρα αξιολόγησης ωστόσο μπορούν να δώσουν μόνο ένα στιγμιότυπο των συνολικών μεταβλητών που είναι σε θέση να επηρεάσουν τις ανταποκρίσεις στη θεραπεία, αφού η προσαρμογή είναι σχετική μόνο εντός των ευρέων κοινοτικών συστημάτων στα οποία ανήκει το κάθε άτομο.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

μέτρα ανθεκτικότητας, αξιολόγηση, ανίχνευση [screening], ψυχομετρικός επανέλεγχος

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Η ροή ως μηχανισμός αλλαγής στη μουσικοθεραπεία: Εφαρμογές στην κλινική πρακτική

Michael J. Silverman & Felicity A. Baker

ΠΕΡΙΛΗΨΗ

Λόγω των δημιουργικών και σκόπιμων εφαρμογών της μουσικής εντός ενός θεραπευτικού πλαισίου, οι μουσικοθεραπευτές ίσως βρίσκονται σε μοναδική θέση σχετικά με την προώθηση εμπειριών που βασίζονται στη ροή [flow] για τους ανθρώπους που έχουν πρόσβαση στις υπηρεσίες τους – οι οποίοι αναφέρονται εδώ

ως «χρήστες». Η ροή, καθώς συνδέεται με πολλούς θετικούς παράγοντες, μπορεί να είναι ιδανική για την ενθάρρυνση και την ενίσχυση μαθησιακών και θεραπευτικών αλληλεπιδράσεων κατά τη διάρκεια της μουσικοθεραπείας. Στόχος αυτού του άρθρου είναι να περιγράψει τη ροή, να προσφέρει ένα πλαίσιο για την κατανόηση της ροής στην μουσικοθεραπευτική κλινική πρακτική και ως έναν πιθανό μηχανισμό αλλαγής ο οποίος θα μπορούσε να εξηγήσει τα αποτελέσματα που παρατηρούνται στην έρευνα με τους χρήστες. Με σκοπό την ενσωμάτωση της βιβλιογραφίας που αφορά τη ροή στη μουσικοθεραπεία, συζητούμε τη σημασία της ροής ως προς τις δεκτικές και τις ενεργητικές μουσικοθεραπευτικές παρεμβάσεις και τις εφαρμογές της ροής στην κλινική πρακτική και την έρευνα. Προτείνουμε τη ροή ως ένα αμφίδρομο κατασκεύασμα στη μουσικοθεραπεία και, βάσει του μοντέλου προσαρμογής ατόμου-δραστηριότητας [person-activity fit model], προσφέρουμε ένα διάγραμμα που ενσωματώνει την δεξιότητα του θεραπευτή με την πρόκληση της παρέμβασης σε μια προσπάθεια ενίσχυσης της μουσικοθεραπευτικής εκπαίδευσης και της κλινικής πρακτικής. Επιπλέον, η ροή μπορεί να αντιπροσωπεύει μια θετικά πλαισιωμένη και λιγότερο παρεμβατική μέθοδο για τη μέτρηση των αντιλήψεων που έχουν οι χρήστες για τα θεραπευτικά αποτελέσματα. Υποστηρίζεται η ανάγκη για περαιτέρω έρευνα που να αξιοποιεί όλες τις πιθανές ερευνητικές προσεγγίσεις με σκοπό την καλύτερη κατανόηση τόσο της έννοιας της ροής όσο και των συνακόλουθων θεραπευτικών επιπτώσεων.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

ροή, μουσικοθεραπεία, βέλτιστες εμπειρίες, προσαρμογή ατόμου-δραστηριότητας [person-activity fit], σύνθεση τραγουδιών, μηχανισμός, αλλαγή

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Πνευματικότητα και μουσικοθεραπεία: Ένα ερευνητικό πρόγραμμα δράσης στην κλινική μουσικοθεραπεία στο πλαίσιο μιας ανθρωπολογικής θεωρίας για την πνευματικότητα

Anita Neudorfer

ΠΕΡΙΛΗΨΗ

Το παρόν άρθρο παρουσιάζει μια μεταθεωρητική προοπτική της μουσικοθεραπείας υπό το πρίσμα της ανθρωπολογικής θεωρίας του Karl Baier για την πνευματικότητα. Ως εργαλείο για τη θεραπευτική αλληλεπίδραση, η θεωρία αυτή προσφέρει μια ερμηνεία των εμπειρικών δεδομένων που προέκυψαν σχετικά με τον προσανατολισμό ζωής ορισμένων αυστριακών ασθενών με καρκίνο σε ένα ογκολογικό κλινικό περιβάλλον. Τα δεδομένα προέρχονται από ένα ερευνητικό πρόγραμμα δράσης που αποτελούσε μέρος μιας πτυχιακής εργασίας στη μουσικοθεραπεία στο IMC University of Applied Sciences στο Κρεμς της Κάτω Αυστρίας. Το πρόγραμμα πραγματοποιήθηκε μεταξύ Νοεμβρίου 2013 και Μαρτίου 2014 στο γενικό νοσοκομείο Wiener Neustadt στην Κάτω Αυστρία. Οι συνεδρίες μουσικοθεραπείας με ασθενείς με καρκίνο (n = 3) καταγράφηκαν οπτικά και ηχητικά, ηχογραφήθηκαν, μεταγράφηκαν αυτολεξεί και αναλύθηκαν. Αυτό το

άρθρο επιχειρεί να δείξει πώς οι βασικές έννοιες της ανθρωπολογικής θεωρίας του Karl Baier περί πνευματικότητας, όπως αυτές της «κατάστασης» [situation], της «βασικής κατάστασης» [ground situation] και της «κατάστασης αποκάλυψης» [disclosure situation], προσφέρουν έναν ερμηνευτικό χώρο για αυτά τα εμπειρικά δεδομένα.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

μουσικοθεραπεία, ανθρωπιστικές επιστήμες, θεραπευτική συνάντηση, πνευματικότητα, πνευματική φροντίδα, προσανατολισμός ζωής

Η **Anita Neudorfer** είναι αυστριακή μουσικοθεραπεύτρια και ακαδημαϊκός στο πεδίο των θρησκευτικών σπουδών με πτυχία από το Πανεπιστήμιο της Βιέννης στις συγκριτικές θρησκευτικές σπουδές (BA, MA) και στις γλώσσες και τους πολιτισμούς της Νότιας Ασίας και του Θιβέτ (BA). Η μεταπτυχιακή της διατριβή στις θρησκευτικές σπουδές είναι αφιερωμένη στην κίνηση του ρυθμού, την κουλτούρα του σώματος και τη γένεση της σύγχρονης πνευματικότητας στις αρχές του 20ού αιώνα. Σπούδασε μουσικοθεραπεία (BSc) στο IMC University of Applied Sciences στο Κρεμς της Κάτω Αυστρίας, όπου πλέον συνεχίζει τις σπουδές της στη μουσικοθεραπεία σε μεταπτυχιακό επίπεδο. Ως κλινική μουσικοθεραπεύτρια εργάζεται στην ψυχιατρική και στην παρηγορητική φροντίδα.

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Μια βιωματική περιγραφή του τανγκό στη μεσοπολεμική Ελλάδα (1922-1940) μέσα από τις αφηγήσεις ζωής ηλικιωμένων σε σπίτια φροντίδας

Αγγελική Κουφού

ΠΕΡΙΛΗΨΗ

Ο επαναστατικός ρυθμός του τανγκό –καθώς και η απλότητα των χορευτικών του βημάτων– συνετέλεσαν στην εξάπλωση της δημοτικότητάς του στην Ελλάδα κατά τη διάρκεια του μεσοπολέμου (1922-1940). Σκοπός αυτού του άρθρου είναι να διερευνήσει τους κοινωνικο-πολιτισμικούς λόγους για τους οποίους το τανγκό έγινε ένας δημοφιλής χορός στην Ελλάδα κατά τη διάρκεια της εποχής αυτής. Πιο συγκεκριμένα, η έρευνα είχε δύο στόχους: να παρουσιάσει μια βιωματική περιγραφή της πρακτικής του τανγκό κατά τη διάρκεια του μεσοπολέμου, καθώς και να διερευνήσει τη συναισθηματική εμπειρία της νοσταλγίας που προκλήθηκε από την ακρόαση δημοφιλών ελληνικών τραγουδιών της μεσοπολεμικής περιόδου. Παρά το γεγονός ότι από τη δεκαετία του 1960 το ελληνικό τανγκό ως μορφή μουσικής ή χορευτικής έκφρασης δεν έχει προεξέχουσα θέση στην Ελλάδα, διεξήγαγα μια διετή εθνογραφική μελέτη σε δύο σπίτια φροντίδας ηλικιωμένων εντός και εκτός Αθηνών. Υιοθετώντας μια διαδραστική μουσική προσέγγιση, που ακολουθήθηκε από συζητήσεις με τους κατοίκους στα σπίτια φροντίδας, ήμουν σε θέση να συγκεντρώσω πληροφορίες σχετικά με την πολιτισμική και την κοινωνική σχέση των ανθρώπων αυτών με το τανγκό. Συγκεντρώθηκαν συνολικά 30 αφηγήσεις από τους κατοίκους. Ιστορικά και λογοτεχνικά κείμενα (π.χ. άρθρα του τύπου της εποχής και μουσικά περιοδικά με σχόλια για τις τάσεις της μουσικής και του χορού της εποχής) χρησιμοποιήθηκαν ως δευτερεύουσες αφηγήσεις.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

τανγκό, Ελλάδα, περίοδος του μεσοπολέμου, σπίτια φροντίδας ηλικιωμένων, αναμνήσεις που εγείρονται από τη μουσική, νοσταλγία

Η **Αγγελική Κουφού** σπούδασε μουσική στο Τμήμα Μουσικών Σπουδών της Κέρκυρας και συνέχισε τις σπουδές της στο ακορντεόν στη Μουσική Ακαδημία Richard-Strauss στο Μόναχο [Richard-Strauss Konservatorium München]. Το 2011 ολοκλήρωσε το διδακτορικό της στο Τμήμα Μουσικών Σπουδών του Πανεπιστημίου Αθηνών. Το θέμα της διδακτορικής της έρευνας ήταν: *«Η κουλτούρα του τανγκό στην Ελλάδα κατά τη διάρκεια του μεσοπολέμου (1922-1940): Μια μουσικολογική και ανθρωπολογική προσέγγιση»*. Η Αγγελική σήμερα ζει μόνιμα στο Λονδίνο όπου μέσα από τις μουσικές της συνεδρίες βοηθά στην προώθηση της κοινωνικοποίησης και στην τόνωση των βασικών κέντρων μνήμης ευάλωτων ανθρώπων που πάσχουν από τη νόσο Αλτσχάιμερ.

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Η τρίτη έκδοση του «Music Therapy Research»: Μια συνέντευξη με την Barbara Wheeler

Barbara Wheeler & Daphne Rickson

ΠΕΡΙΛΗΨΗ

Σε αυτή τη συνέντευξη η καθηγήτρια Barbara Wheeler αναστοχάζεται σχετικά με την ανάπτυξη της τρίτης έκδοσης του «Music Therapy Research» (Wheeler & Murphy 2016). Μέσα από ένα ιστορικό πρίσμα που καλύπτει περισσότερες από δύο δεκαετίες, αναφέρεται σε σημαντικούς συναδέλφους της που έπαιξαν καταλυτικό ρόλο στον χώρο της μουσικοθεραπείας και επισημαίνει τους τρόπους με τους οποίους η κάθε έκδοση του βιβλίου έκανε ανοίγματα ώστε να περιλαμβάνει ένα ευρύτερο φάσμα διεθνών οπτικών και προσεγγίσεων στην έρευνα. Εξηγώντας τις σημαντικές αλλαγές στις οποίες προέβη η ίδια και συν-επιμελήτριά της Kathleen Murphy στην τρίτη έκδοση, υποδεικνύει τις τρέχουσες αναδυόμενες τάσεις και τα σύγχρονα ζητήματα στο ολοένα μεταβαλλόμενο τοπίο της μουσικοθεραπευτικής έρευνας.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

έρευνα για τη μουσικοθεραπεία, ποσοτική έρευνα, ποιοτική έρευνα, έρευνα βασισμένη στον αντικειμενισμό [objectivist research], έρευνα βασισμένη στον ερμηνευτισμό [interpretivist research]

Η **Barbara L. Wheeler** (PhD, MT-BC) κατέχει τον τίτλο της επίτιμης καθηγήτριας στο Montclair State University, όπου δίδαξε από το 1975 έως το 2000. Το 2000 ξεκίνησε το πρόγραμμα μουσικοθεραπείας University of Louisville, απ' όπου και συνταξιοδοτήθηκε το 2011. Η Barbara Παρουσιάζει και διδάσκει τόσο στις ΗΠΑ όσο και διεθνώς με διορισμούς στα τμήματα των ακόλουθων πανεπιστημίων: University of Applied Sciences Würzburg Schweinfurt, στο Τμήμα Κοινωνικών Σπουδών στο Würzburg στη Γερμανία και στη Μουσική Ακαδημία Karol Szymanowski στο Κατοβίτσε στην Πολωνία. Όλη η σταδιοδρομία της χαρακτηρίζεται από την ενεργή κλινική της δράση και από τη συνεργασία της με ένα εύρος πελατειακών ομάδων. Η Barbara επιμελήθηκε το *Music Therapy Handbook* (2015) και τις τρεις εκδόσεις του *Music Therapy Research* (1995, 2005, 2016), και είναι η μία από τις συγγραφείς των δύο εκδόσεων του *Clinical Training Guide for the Student Music Therapist* (2005, υπό έκδοση). Είναι επίσης συγγραφέας πολυάριθμων άρθρων και κεφαλαίων. Στο παρελθόν διετέλεσε πρόεδρος της Αμερικανικής Ένωσης Μουσικοθεραπείας (American Music Therapy Association, AMTA) και επιμελήτρια συνεντεύξεων του επιστημονικού περιοδικού *Voices: A World Forum for Music Therapy*. Το 2016 η Barbara τιμήθηκε με το βραβείο Award of Merit από την AMTA.

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Η **Daphne Rickson** είναι επίκουρη καθηγήτρια στο μεταπτυχιακό πρόγραμμα μουσικοθεραπείας στο Te Koki, New Zealand School of Music, στο Victoria University of Wellington. Έχει εργαστεί ως μουσικοθεραπεύτρια με ένα εύρος πληθυσμιακών ομάδων, αλλά κυρίως με παιδιά και εφήβους σε σχολικά πλαίσια. Τα πρόσφατα ερευνητικά της προγράμματα περιλαμβάνουν την κριτική ανάλυση της έννοιας της αναπηρίας και τη διερεύνηση της μουσικής ως πηγής ένταξης, συμπεριλαμβάνοντας και τη συμμετοχική έρευνα με νέους ανθρώπους με νοητική αναπηρία. Αυτή τη στιγμή μελετά τον ρόλο του τραγουδιού στην ευημερία των δασκάλων και των παιδιών σε ένα σχολείο του Christchurch της

Νέας Ζηλανδίας, το οποίο έχει πληγεί σοβαρά από σεισμούς. Είναι συγγραφέας πολυάριθμων άρθρων σε επιστημονικά περιοδικά και μία από τις συγγραφείς του βιβλίου του 2014 *Creating Music Cultures in the Schools: A Perspective from Community Music Therapy*. Η Daphne είναι αναπληρώτρια επιμελήτρια του Approaches.

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Είκοσι χρόνια μουσικοθεραπείας στο Berklee College of Music

Suzanne Hanser

ΠΕΡΙΛΗΨΗ

Αυτή η αναφορά αποτελεί έναν απολογισμό της ίδρυσης και της ανάπτυξης του Music Therapy Department and Institute στο Berklee College of Music στη Βοστώνη, Μασσαχουσέττη, ΗΠΑ. Κάνει μια αναδρομή στα τελευταία 20 χρόνια αναφορικά με την ανάπτυξη της σχολής και του προγράμματος σπουδών, των ειδικών πρωτοβουλιών του, των δρώμενων καθώς και των τάσεων στην εκπαίδευση και την κατάρτιση των μουσικοθεραπευτών. Η αναφορά επεξηγεί τους παράγοντες εκείνους που καθοδηγούν τόσο την εστίαση όσο και την αλλαγή του προγράμματος.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

ανάπτυξη προγράμματος, μουσικοθεραπεία, πρόγραμμα σπουδών, ιστορία της μουσικοθεραπείας

Η **Suzanne B. Hanser** (EdD, MT-BC) είναι η ιδρυτική πρόεδρος του Τμήματος Μουσικοθεραπείας στο Berklee College of Music. Η Δρ. Hanser υπήρξε ταυτόχρονα πρόεδρος τόσο της Παγκόσμιας Ομοσπονδίας Μουσικοθεραπείας [World Federation of Music Therapy] όσο και της Εθνικής Ένωσης Μουσικοθεραπείας [National Association for Music Therapy]. Έγραψε το *New Music Therapist's Handbook*, σε συνεργασία με την Δρ. Susan Mandel έγραψε το *Manage Your Stress and Pain* (βιβλίο και CD), ενώ ήταν η συγγραφέας και του *Integrative Health through Music Therapy: Accompanying the Journey from Illness to Wellness*. Έχει τιμηθεί με το διεθνές βραβείο National Research Service Award από τη NIA, το βραβείο των εκδόσεων Sage, και το βραβείο Lifetime Achievement Award της Αμερικανικής Ένωσης Μουσικοθεραπείας [American Music Therapy Association].

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