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Σημείωμα σύνταξης

Προωθώντας διεπιστημονικούς και πολυπολιτισμικούς διαλόγους

Γιώργος Τσίρης[1,2] & Daphne Rickson[3]

[1]Nordoff Robbins Scotland, Ηνωμένο Βασίλειο; [2]Queen Margaret University, Ηνωμένο Βασίλειο;

[3]Victoria University of Wellington, Νέα Ζηλανδία

Καλώς ήλθατε στην πρώτη περιοδική έκδοση του *Approaches* για το 2017! Η περσινή χρονιά ήταν αφιερωμένη σε δύο ειδικά τεύχη: *Μουσικοθεραπεία, δραματοθεραπεία, χοροθεραπεία και εικαστική θεραπεία: Διεπιστημονικοί διάλογοι* (Κάρκου 2016) και *Η Ρυθμική Dalcroze στη μουσικοθεραπεία και την ειδική μουσική παιδαγωγική* (Habron 2016). Η διεπιστημονική εστίαση αυτών των τευχών αντικατοπτρίζει το όραμα του *Approaches*: να προσφέρει διαφορετικές προοπτικές σχετικά με την πρακτική, το επάγγελμα και την επιστήμη της μουσικοθεραπείας προωθώντας πολυφωνικούς διαλόγους και γεφυρώνοντας τοπικές και παγκόσμιες πτυχές της μουσικής, της υγείας και της ευεξίας. Στόχος μας είναι να συνεργαζόμαστε με μελετητές, ερευνητές και επαγγελματίες από διάφορους τομείς που σχετίζονται με τη μουσικοθεραπεία, ενώ προσπαθούμε να δημιουργούμε τις συνθήκες για υγιείς και ακαδημαϊκά ισχυρές συζητήσεις. Μια ανοιχτή και συνάμα κριτική στάση προς διαφορετικές, ακόμη και αντικρουόμενες απόψεις, καθώς και ένας σημαντικός βαθμός μάθησης και εκ νέου μάθησης (Tsiris et al. 2016) χρειάζονται για την επίτευξη αυτού του οράματος.

Με αυτήν την ευκαιρία θα θέλαμε να ευχαριστήσουμε τα μέλη της συντακτικής ομάδας του *Approaches*, τους κριτές και κυρίως τους συγγραφείς για την προώθηση αυτού του οράματος στο περιοδικό. Αρκετοί από τους συναδέλφους μας έχουν υπηρετήσει για πολλά χρόνια ως μέλη της συντακτικής ομάδας – ορισμενοί από την ίδρυση του περιοδικού το 2008. Πρόσφατα εισαγάγαμε ένα πενταετές πρόγραμμα που σημαίνει ότι ορισμένα από τα τρέχοντα μέλη της ομάδας μας θα ολοκληρώσουν τη θητεία τους στο τέλος αυτού του έτους. Εκφράζουμε την εκτίμησή μας για τη σκληρή δουλειά και αφοσίωσή τους όλα αυτά τα χρόνια. Ο ρόλος τους ήταν ζωτικής σημασίας για την ανάπτυξη του *Approaches*. Ευχαριστούμε επίσης τους πρώην και νυν χορηγούς του περιοδικού.

Η παρούσα έκδοση ξεκινά με μία ειδική ενότητα με τίτλο *Μουσικοθεραπεία: Ένα επάγγελμα για το μέλλον*. Υπό την επιμέλεια της Inge Nygaard Pedersen, αυτή η ειδική ενότητα περιλαμβάνει μια σειρά κειμένων από ένα συμπόσιο που πραγματοποιήθηκε στις 15 Απριλίου 2016 στο Aalborg University της Δανίας. Τα κείμενα αυτά συντάχθηκαν από 15 συγγραφείς οι οποίοι διερευνούν δύο καίρια ερωτήματα: *«Γιατί μουσική;»* και *«Γιατί και πότε χρειάζεται ένας μουσικοθεραπευτής;»* Αυτή η ενότητα δομείται σε τρεις τομείς εργασίας της μουσικοθεραπείας: i) ψυχική υγεία, ii) φροντίδα της άνοιας και νευροαποκατάσταση, και iii) προσκόλληση/επικοινωνία και αναπτυξιακά προβλήματα.

Εκτός από αυτή την ειδική ενότητα, το παρόν τεύχος συμπεριλαμβάνει μια ευρεία σειρά άρθρων.Το περιεχόμενό τους αντανακλά όχι μόνο τη διεπιστημονική αλλά και την πολυπολιτισμική δέσμευση του περιοδικού. Η Bethan Lee Shrubsole περιγράφει τη μουσικοθεραπευτική της πρακτική στη βόρεια Ουγκάντα, ενώ οι Elizabeth Coombes και Michal Tombs-Katz γράφουν σχετικά με την προσφορά μουσικών προγραμμάτων διαμοιρασμού δεξιοτήτων στη Δυτική Όχθη. Το κρίσιμο καθήκον παροχής ερευνητικά τεκμηριωμένων πρακτικών για την ανάπτυξη και συνέχιση υπηρεσιών

μουσικοθεραπείας είναι το αντικείμενο συζήτησης σε δύο διαφορετικά αλλά συμπληρωματικά άρθρα από την Claire Cartwright (Ηνωμένο Βασίλειο) και την Okiko Ishihara (Ιαπωνία) αντίστοιχα. Στο τελευταίο άρθρο, οι Melissa Mercadal-Brotons, Patricia Sabbatella και María Teresa Del Moral Marcos κάνουν μια λεπτομερή έκθεση σχετικά με την ιστορία, την παρούσα κατάσταση και το πιθανό μέλλον της μουσικοθεραπείας στην Ισπανία σχετικά με την κατάρτιση, την έρευνα και την επαγγελματική πράξη. Αναφέρουν διάφορα ενθαρρυντικά επιτεύγματα, αλλά υποστηρίζουν ότι χρειάζεται ακόμη σημαντική εργασία προς την επίτευξη ενός οργανωμένου και ώριμου επαγγέλματος. Οι προκλήσεις που συνδέονται με την επαγγελματο-ποίηση, συμπεριλαμβανομένης της δημιουργίας ενός κοινού οράματος για τον επαγγελματικό ρόλο των μουσικοθεραπευτών και της επίσημης αναγνώρισης της μουσικοθεραπείας από τις εθνικές κυβερνήσεις, θα είναι οικείες ανησυχίες και σε άλλες χώρες. Και πράγματι, παρόμοιες σκέψεις και ανησυχίες έχουν περιγραφεί στο ειδικό τεύχος του *Approaches* σχετικά με την μουσικοθεραπεία στην Ευρώπη (Ridder & Tsiris 2015). Συνεχίζοντας με το θέμα της επαγγελματοποίησης, στη συνέντευξή της με την Ιωάννα Ετμεκτσόγλου, η Elizabeth Coombes προσφέρει γνώσεις σχετικά με τις προκλήσεις και τις ευκαιρίες ενός νέου μουσικοθεραπευτικού προγράμματος κατάρτισης βάσει της εμπειρίας της στο μεταπτυχιακό πρόγραμμα μουσικοθεραπείας στο Πανεπιστήμιο της Νότιας Ουαλίας στο Ηνωμένο Βασίλειο.

Σε αυτό το τεύχος θα βρείτε ακόμη έναν αριθμό από βιβλιοκριτικές, αναποκρίσεις από συνέδρια και αφιερώματα. Τα τελευταία αφορούν δύο άτομα που απεβίωσαν το 2015 και είναι προς τιμήν της συμβολής τους στο πεδίο. Το πρώτο αφιέρωμα αναφέρεται στον Oliver Sacks και στη σημαντική επίδρασή του στη σύγχρονη σκέψη για τη μουσική και την ευεξία.Το δεύτερο αφιέρωμα αφορά τον Andrew O'Hanrahan, έναν μουσικοθεραπευτή από το Ηνωμένο Βασίλειο το έργο του οποίου άγγιξε τις ζωές πολλών.

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Editorial

Fostering interdisciplinary and multicultural dialogues

Giorgos Tsiris[1,2] & Daphne Rickson[3]

[1]Nordoff Robbins Scotland, UK; [2]Queen Margaret University, UK;

[3]Victoria University of Wellington, New Zealand

Welcome to the first 2017 edition of Approaches! Last year was dedicated to two special issues: *Music, Drama, Dance Movement and Art Therapy: Interdisciplinary Dialogues* (Karkou 2016) and *Dalcroze Eurhythmics in Music Therapy and Special Music Education* (Habron 2016). The interdisciplinary focus of these two special issues highlights the vision of *Approaches*: to provide diverse perspectives on music therapy practice, profession and discipline by fostering polyphonic dialogues and by linking local and global aspects of music, health and wellbeing. We aim to work with scholars, researchers and practitioners from different fields related to music therapy while we try to create the conditions for healthy and academically robust debates. An open, yet critical, stance towards diverse, even conflicting, views, as well as a huge amount of learning and re-learning (Tsiris et al. 2016), is needed for the accomplishment of this vision.

We would like to take this opportunity to thank Approaches' editorial team members, the reviewers and, most importantly, the authors for promoting this vision within the journal. Many of our colleagues have served for several years as editorial team members – some since the journal's establishment in 2008. We recently introduced a five-year pattern which means that some of our current team members will be stepping down at the end of this year. We express our sincere appreciation for their hard work and commitment over the past years. Their role has been vital for the growth of Approaches. Our thanks also go to the past and current sponsors of Approaches.

This edition begins with a special feature entitled *Music Therapy: A Profession for the Future*. Guest edited by Inge Nygaard Pedersen, this special feature includes a series of papers from a symposium held on 15th April 2016 at Aalborg University, Denmark. Written by 15 authors, these papers explore two key questions: '*Why music?'* and *'Why and when is a music therapist needed?'* This feature is organised according to three areas of music therapy work: i) mental health, ii) dementia care and neuro-rehabilitation, and iii) attachment / communication and developmental problems.

In addition to this special feature, this edition brings together a rich collation of articles, interviews, book reviews, conference reports and tributes. The content reflects our commitment not only to interdisciplinary but also to multicultural issues. Bethan Lee Shrubsole reflects on her music therapy practice in northern Uganda, while Elizabeth Coombes and Michal Tombs-Katz reflect on their therapeutic music skill-sharing work in the West Bank. The crucial task of producing practice-based evidence to support the establishment and continuation of music therapy services is addressed in two different but complementary articles by Claire Cartwright (UK) and Okiko Ishihara (Japan) respectively. In the final article, Melissa Mercadal-Brotons, Patricia Sabbatella and María Teresa Del Moral Marcos provide a comprehensive and detailed report on the history, current state, and potential future of music therapy in Spain from the perspectives of training, research and professional practice. They note many exciting accomplishments, yet argue that considerable work still needs to be done to achieve an organised and mature profession. The challenges associated with professionalisation, including the creation of a unified vision of the professional role of music

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therapists and official recognition of music therapy by national governments, will be familiar concerns within other countries. And indeed, similar considerations and concerns have been outlined in Approaches' special issue on music therapy in Europe (Ridder & Tsiris 2015). Keeping with the theme of professionalisation, Elizabeth Coombes' interview with Ioanna Etmektsoglou offers insights into the challenges and opportunities of a new music therapy training programme drawing on Coombes' experience at the MA Music Therapy programme at the University of South Wales, UK.

In this edition you will also find a number of book reviews, conference reports and tributes. The latter are dedicated to two individuals who passed away in 2015, in memory of their contribution to the field. The first of the tributes is to Oliver Sacks and his tremendous impact on our contemporary thinking about music and wellbeing. The second tribute is to Andrew O'Hanrahan, a UK-based music therapist whose work touched the lives of many.

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Special feature

Music therapy: A profession for the future

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

Lectures and reflections from the international symposium Aalborg University, Denmark, 15 April 2016

Guest editor: Inge Nygaard Pedersen

This special feature is a series of papers from a symposium held on 15th April 2016 at Aalborg University, Denmark on the topic: *'Music therapy: A profession for the future'*. The two core questions listed in the title: '*Why music? Why and when is a music therapist needed?'* were the vehicle of the day for both the lectures presented on the symposium day and for the following discussions among the participants.

All together 15 authors have contributed from five universities: Aalborg University (Denmark), University of Melbourne (Australia), Anglia Ruskin University (United Kingdom), University of Bergen (Norway) and University of Oslo (Norway). The special feature brings worked-through reflexive introductions, lectures and reflection papers in three parts, where each part is related to one of the three populations chosen for the roundtables on the symposium.

The organisers of the symposium wondered if common answers to the two core questions in the profession of music therapy would emerge at an international base during the day, or if multiple ideas and subjective answers to the questions would come up.

As the contributions show, it is mostly multiple ideas; yet with regard to case material, the way of carrying out music therapy in a relationship with the users of music therapy is very similar. The theoretical understanding and ideological positions are different. There still seems to be, however, a growing integration of theories and ideas by many presenters and discussion partners, and there seems to be an interest in finding overlapping concepts in the field that can clarify and simplify the dissemination of information relating to the music therapy profession.

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GUEST EDITORIAL

Inge Nygaard Pedersen

Aalborg University, Denmark

Structure of the symposium

The symposium at Aalborg University held on 15th April 2016 was structured in three roundtables, where the two core questions '*Why music?'* and '*Why and when is a music therapist needed?'* were in focus. These questions created the basis for lectures and discussions concerning 1) music therapy in mental health, 2) music therapy in dementia care and neuro-rehabilitation, and 3) music therapy in the area of attachment/ communication and developmental problems for children, adolescents and families.

Each roundtable included three lecture presenters, three discussion partners and one moderator. Each lecture was limited to 15 minutes and the discussion time for the three discussion partners and the presenters had a time limit of 55 minutes with the last ten minutes reserved for the audience questions and comments.

The presenters at roundtable 1 were Inge Nygaard Pedersen (Denmark), Denise Grocke (Australia) and Jos De Backer (Belgium). The discussion partners were Helen Odell-Miller (United Kingdom), Charlotte Lindvang (Denmark) and Sanne Storm (Faroe Islands). The moderator was Niels Hannibal (Denmark).

The presenters at roundtable 2 were Hanne Mette Ridder (Denmark), Helen Odell-Miller (United Kingdom) and Wolfgang Schmid (Norway). The discussion partners were Bolette Daniels Beck (Denmark), Jörg Fachner (United Kingdom) and Cheryl Dileo (USA). The moderator was Brynjulf Stige (Norway).

The presenters at roundtable 3 were Stine Lindahl Jacobsen (Denmark), Katrina McFerran (Australia) and Gro Trondalen (Norway). The discussion partners were Ulla Holck (Denmark), Karette Stensæth (Norway) and Helen Loth (United Kingdom). The moderator was Cheryl Dileo (USA).

Not all presenters chose to submit their paper for this special feature.

Topic of the symposium

Niels Hannibal from Aalborg University suggested the topic for the day. His colleagues, Hanne Mette Ridder and I, agreed and planned for this targeted focus for the symposium. We had participated in a similar symposium at Temple University, USA on 10th April 2015 with the title *'Envisioning the Future of Music Therapy'* where we listened to how research has given a foundation for the future of music therapy. From that perspective, the future looked promising (Dileo 2016). All three of us wondered if common answers to the two core questions in the profession of music therapy would emerge at an international base during the day, or if multiple ideas and subjective answers to the questions would come up.

As the contributions show, it is mostly multiple ideas; yet with regard to case material, the way of carrying out music therapy in a relationship with the users of music therapy is very similar. The theoretical understanding and ideological positions are different. There still seems to be, however, a growing integration of theories and ideas by many presenters and discussion partners, and there seems to be an interest in finding overlapping concepts in the field that can clarify and simplify the dissemination of the valuable profession of music therapy.

Structure of the special feature

All together 15 participants have contributed to this special feature including eight presenters. The special feature, as mentioned above, is presented in three parts following the topics of each roundtable.

In line with the open-ended, reflective and unfolding nature of the symposium, each contributor was invited to organise their contribution as it seemed appropriate to them without having to follow a pre-defined structure. Furthermore, this openness hopefully helps to show the multiple ideas around the two questions by the lecture presenters, discussion partners and moderators.

This special feature concludes with a postlude by Lars Ole Bonde (Denmark), who took notes during the day. In an attempt to give an overview of the symposium, the postlude brings together the main ideas explored in the symposium in response to the core questions *'Why music?'* and *'Why and when is a music therapist needed?'*.

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PART ONE: MUSIC THERAPY IN MENTAL HEALTH

Roundtable presenters:
Pedersen, Grocke, De Backer

Discussion group members
Odell-Miller, Lindvang, Storm

Moderator: Hannibal

A reflexive introduction

Music therapy in mental health

Helen Odell-Miller
Anglia Ruskin University, United Kingdom

The three lecture papers by Inge Nygaard-Pedersen, Jos De Backer (paper not submitted for this article) and Denise Grocke are diverse, which is not surprising given the expansive music therapy practice in the 21st century. There are cultural, educational and theoretical differences. This is a healthy state of affairs, as one approach does not suit all our populations of both service users (patients or participants) and therapists. The papers also contain some similar themes, and our mutual reflections draw out both similarities and differences from all three papers. This part is both a reflection on the three lectures and an introduction to the two lecture papers presented here in part one of the article. Part one finally presents a reflection on the three lectures and the two questions from another perspective by the moderator of this roundtable for mental health care, Niels Hannibal.

Adult mental health in the 21st century covers a large field, comprising populations with diagnosed mental health problems, and those within public health services who have, for example, addictions, personality disorders and other functional mental health disorders. In modern times mental health is sometimes considered as emotional imbalance rather than illness, yet a medical diagnostic model is still in place in many services. At the same time, inclusion, recovery approaches and dispelling stigma are central to mental health agendas for people experiencing psychiatric disorders and less severe mental health problems.

Both Pedersen and De Backer discuss the importance of the qualities of music to enable connection: synchronicity, a shared language, and a place for non-symbolic linking. Pedersen discusses a possible trajectory for hospitalised

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people with acute mental illness: later, in the recovery stage perhaps, a music therapist may not be needed and community musicians or teachers may suffice. Pedersen also highlights that music therapists are uniquely placed within an improvisational framework to decide when harmony and dynamic musical interaction are needed; or that grounding using a monotone might be more appropriate. Grocke focuses upon the use of song with composition and lyric analysis, highlighting research and the importance of songwriting for people with enduring serious mental health problems, no longer in the acute phase of their process.

In reflecting upon the question *'Why and when is a music therapist needed?'*, people with long and enduring mental health problems may need music therapy throughout their journey through mental health services. Specific models or interventions can move from a more introspective approach (as in De Backer's sensorial play prior to musical form) right through to the use of musical structure and creative uses of harmony, melody and, of course, meaningful lyrics.

It is important to mention recent research here. Carr et al. (2013), and Carr (2014), report in-depth research investigating music therapy models on acute psychiatric wards. This research highlights participants' feedback reporting enjoyment of the use of known song structures, and structured improvisation, and also reports a preference for a directive attitude of the qualified music therapist in groups. The social element of music therapy, being present in music therapy groups, can enable insights and the development of relationships for adults with mental health problems. This point is also mentioned by Grocke and Pedersen in their papers. Furthermore, Carr's recent research (looking at over 100 participants in group music therapy) found that participants reported they enjoyed seeing their fellow group members actively singing, playing and participating in a whole group event – or excelling in solo parts of the group. The idea of music as a collective social and creative medium, with the music therapist using their psychological and musical training to create music which is either new or based upon pre-composed songs, really resonates with Grocke's findings in a different cultural setting. Currently, Carr et al. (2016) are investigating the use of song and improvisation approaches in music therapy for out-patient groups for people with depression in a new feasibility randomised controlled trial.

Individual music therapy approaches are also described as important for people with personality disorders by both Pedersen and De Backer. They each draw upon psychoanalytic theory, using music as an intense connection where the therapist listens, contains and facilitates growth through free improvisation with the therapist using verbal and musical interpretation/reflection/interaction.

This highlights that a music therapist is needed to link psychological and musical thinking – and that the music therapist should always be a highly trained musician who can therefore work musically at any level required. Music therapists frequently interact with music, reflecting back to the client, verbally and musically, in the same way a psychoanalyst uses talking and thinking (Hannibal 2014, 2016; Odell-Miller 2016).

A music therapy approach for people with serious mental health problems is focused upon by Pedersen, De Backer and Grocke. They each emphasise the importance of the unique expertise of the music therapist as improviser, composer, singer, songwriter, instrumentalist, musical interpreter and listener. Music therapists focus upon the unique intense musical relationship, especially with people who are not ready to use words but can 'think' and work musically. Pedersen provides a service-wide document where she is clear about what is needed when and why, and she touches upon the ambiguous nature of music suggesting that it is a kind of language but may never actually represent anything too concrete. She believes music can have a meaning for something that cannot be expressed in words – 'tacit meaning'. All authors touch upon affect regulation as a major factor in music therapy in this field.

The function of the music therapist in different roles, such as therapist, advisor, supervisor and educator is also crucial to the question about why and when a music therapist is needed. There is consensus about the important element of listening; both the music therapist's ability to listen to the non-verbal, musical cues but also an ability to simply allow space and listen to patients. In contrast, the psychoanalytically-informed music therapist might also use words following and between music-making to interpret, investigate, and so on.

In the future, music therapists will probably apply the role of educator or consultant even more to further share their expertise and knowledge, and

to teach other professions to use music to benefit the users of mental health care. This is a process that has started in several areas of music therapy and also in psychiatry. Here, music therapists are functioning as consultants who teach the staff how to use, for example, music pillows, and apps like the Music Star (Lund, Bertelsen & Bonde 2016), in order to facilitate relaxation and better sleep quality among patients.

Research and evaluation is important here, and a consideration of the most helpful ways to communicate about the impact of music therapy. How important is it to communicate about music therapy to multidisciplinary teams from a musical perspective, for example, showing musical examples rather than only talking about music therapy? How much do we need standardised research measures in research? Clearly both are needed, and clarity about the effects of music therapy is needed for the multidisciplinary team.

The profession needs to develop this area to improve understanding about the benefits of music therapy, and for whom. In short-term music therapy, for example in modern acute admission ward settings, a period of only two weeks is available for treatment before patients are discharged. This can be a challenge. We also need to recognise when music therapy is contra-indicated.

In summary, thinking forward, we need to continue rigorous research in this area, including standardised psychological and physiological measurements, and musical measures. We do have these now to some extent, as demonstrated by many research projects. The music therapist's self-agency, through working in the transference and countertransference, is known to be crucial, but more research about the music therapist's process is needed. Qualitative quantitative and mixed methods research which focuses upon diagnostic aspects, user and carer's needs, the context and environment, and specific music therapy elements within sessions, is needed.

Finally, the relationship between music therapy and other experiential arts therapies is worthy of further research. There are many similarities between the different arts therapies, but so far there is not a huge body of research demonstrating which arts therapies might be suitable for which situations and needs, and when and how it should be delivered. In conclusion, music therapy has a specific emotional, intellectual, psychological, physiological and social relevance for adults with mental health issues, and there is convincing research to substantiate this. In the future, more knowledge is needed about specific beneficial outcomes and new research is continuing to investigate these questions.

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Lecture 1

Music therapy in psychiatry/mental health

Inge Nygaard Pedersen
Aalborg University, Denmark

Introduction

In this lecture paper, I will offer some perspectives from primarily my personal experiences in clinical practice in mental health with different patient populations spanning 20 years – primarily people suffering from personality disturbances, schizophrenia and depression. These perspectives will be illustrated through a case study. They have been documented in multiple publications (Pedersen 1999, 2002, 2002a, 2003, 2007, 2012, 2014a, 2014b). I am aware that there can be a range of perspectives on these topics.

Why music?

I will start by going back to some statements on what could be a therapeutic understanding of music, which was first described by my colleague, Lars Ole Bonde, firstly in 2002, then in 2011 and 2014. I want to step back to some of these formulations as I think they are long-lasting and still important today. I do agree with them and I think they are especially important for the understanding of why music is applicable in mental health care.

One of his statements is that although music is a type of language it is:

> "[…] not an unambiguous, discursive language, and it can never represent or designate phenomena of the external or internal world with the exactness of verbal, categorical language. Music can be characterized as an ambiguous, representative, symbolical language" (Bonde 2002: 39).

I think this is a very important explanation as to why music is applicable in mental health care. The patient cannot be 'interpreted' directly from the musical expression, and the patient is the agent of his/her experiences in musical expressions and during music listening. Still, these musical expressions and experiences can be shared with a music therapist who is carefully listening and interacting without interpretation, unless this is mutually understood as a positive opportunity for the patient to understand specific developmental steps.

Another description from Bonde is:

> "[…] music can contain and express meaning beyond the pure musical or aesthetic content - music can be a direct expression of a client´s emotions, or a musical representation – symbolic or metaphorical – of spiritual or complicated psychological states and conditions, or the musical expression can be an analogy to the client's being-in-the- world" (Bonde 2002: 39).

This second important statement clarifies why music is therapeutically meaningful in mental health care. It underlines that music can mirror patterns in the therapist/patient relationship both explicitly and implicitly experienced, and that it can offer a mutual, musical space to develop and try out new relational patterns.

Bonde also claims that:

> "[…] music can have a meaning, even if this can´t be expressed in words. This 'tacit knowledge' or 'inexpressible meaning' can be found at different levels" (Bonde 2009: 39).

A former patient of mine, who would tend to intellectualise when talking with other people, exclaimed – after having played the piano for the first time in the first music therapy session, and after a deep sigh – "I have no words!". He had never played music before. As his music therapist I thought this was a very important moment for him as he was someone who usually avoided deeper contact with other people through the expression of words which he did not seem to be emotionally connected with.

Understanding clinical work in mental health

My etiological and pathogenic understanding of mental health problems is based on a bio-psychosocial understanding with an emphasis on

the vulnerability-stress model. This understanding is combined with an understanding of clinical practice as unfolded in a phase-specific case work. This is in line with other clinicians and researchers in music therapy such as Bradt (2012), who claims that instead of examining the benefits of a specific music therapy treatment, investigators can rather employ a stage approach to researching. My theoretical foundation draws on a psychodynamic, existential, relational and psychoanalytical understanding of mental health. To sum up my understanding of music therapy in mental health, the following statements (summaries gathered from different publications) provide important guidelines:

- Different music therapy interventions are often needed in different phases of the case work (phases are not always linear – they are most often circular) (Pedersen 2014a, 2016).
- The timing of the music therapy interventions is of essence (Pedersen 2002, 2012, 2014a, 2016).
- Following the process of the patient is more important than following a specific approach in music therapy (Pedersen 2012, 2014a, 2016).
- The music therapist needs to apply a state of *disciplined subjectivity* in the relationship to stay open-minded to the life world of the patient at the same time as stay grounded in her/his own life world (Pedersen 2007).

Phases in understanding developmental steps in mental health problems in clinical work

If I consider some phases in the progression of mental health illnesses – independent of specific diagnoses – I would start with the *phase of acute conditions*, phase A. In this phase the patient will often experience much chaos and be suspicious of being misunderstood or misinterpreted, since this phase includes being interviewed and observed for a diagnosis. Here the understanding of music being an ambiguous, representative, symbolic language is important in music therapy offered as a complementary intervention. The patient can express him/herself in music in a way that can´t be exactly interpreted. This form of expression can release tensions – tensions built up from a state of keeping back personal expressions due to a strong anxiety of not being understood.

The music therapist is important as a supporter and a mirror for the patient in this phase. In addition, the music therapist is important as a stable and empathic listening person outside the inner chaos of the patient – an anchor for the patient when playing music/listening to music.

One of my music examples from clinical work with the patient mentioned above (see CD track 3 in Wigram, Pedersen & Bonde 2002), illustrates that the patient (diagnosed with personality disturbances, being obsessive compulsive and highly intellectualising) is playing quite fragmented music at either the lower or the upper range of the piano while I, as the music therapist, am playing one tone in the middle range of a second piano, in a stable heartbeat rhythm. The patient had never played the piano before. The music mirrors the relationship patterns between us here and now, where the patient takes turns in a) slightly moving towards the stable sounding centre I am offering in my musical interplay, and b) moving away from it. The patient tells me that he is not able to be in a stable contact with either himself or with anyone else. The harmonies, however, which emerge in the music when the patient moves towards the sounding centre, loosens tensions and anxieties around this problem. The musical interaction encourages the patient to seek contact due to these harmonies emerging between the tones when he moves towards this stable sounding centre. In this phase of an acute condition, an important role of the music therapist can also be to introduce supportive music for the patient and other team members to listen to. This can help the patient listen to such music, selected by music therapists, when needed and possible. So: *music can serve as a constant, safe place* both actively as (a stable sounding centre) and receptively (when listening to a piece of music over and over again).

In a following phase, which could be titled as the *phase of identifying symptoms*, phase B – the focus is on identifying a diagnosis or recognising patterns of the person suffering from mental health problems. Here the music can offer a safe place and can function as a regulator and as a container for reactions to the situation. The music therapist is needed to ensure and mirror a safe place for this sensitive process, and an empathic listening attitude of the music therapist is important here. The music therapist needs to listen to the depth of the suffering of the patient – listening through

empathic identification with the patient. I like to reflect that I am listening to myself listening to the patient in the music. The role of the music therapist in this phase is also to assure the patient that strong reactions and emotions are perfectly acceptable. They can be contained and accepted and expressed in the music; the therapist needs to be a mirror of hope.

In another clinical music example with the same patient (see CD track 4 in Wigram, Pedersen & Bonde 2002), he describes himself – when entering the music therapy room – as being totally restless and anxious. He is not able to concentrate at all or to sit down. He follows the encouragement from me to express this condition, just as it is, in music. I follow his strong expressions and aim at containing them at the same time, as I am aware of keeping a stable pulse to continue the function of a stable sounding centre from phase A.

In the third phase, a *phase of developing and building up capacity to cope with chaos, anxiety or hopelessness*, phase C is unfolded, and the music arena and the music therapist can be partners regarding the experiencing of struggles and receptions. In this same phase music can also be a language of expression through which the patient can feel strengths and resources not so easily experienced elsewhere (music can be an agent, a promoter, and a possible transformer). The role of the music therapist is to be a stable partner who shares and participates in these processes. The music therapist has to be aware of, understand and – with careful timing – react on countertransference experiences either musically or verbally if possible, to raise the understanding of the therapist/patient relationship in the 'here and now'. How are we related? What is my contribution to the relationship and what is the perspective of the other partner? The music offers *a potential space* (Hansen 2007; Winnicott 1990) for mutual development of the relationship – and literally playing with and exercising new relational capacities.

In the next phase, a *phase to identify possible limitations of being in the world and possible new resources for the future*, phase D, the music can help to establish a new identity with more stable inner resources (e.g. through creations of own songs or through listening to preferred music). Musical form can offer a structure in which the patient can be in flow with an emerging integrated identity. Music can be an important carrier of identity in this phase. In a third clinical music example with the same patient (see CD track 8 in Wigram, Pedersen & Bonde 2002), he has come to a phase where he no longer needs a stable person outside and related to himself to avoid chaos and anxiety. He can now understand that his former need of controlling others in a relationship due to anxiety and a poor feeling of coherence of identity is no longer prevailing. The patient can act more freely in the musical interplay and can join a common flow in the improvisation, and this can be understood as an analogy of how he now has the capacity to relate to other people in a more flexible way.

I want to present a short statement from the same patient – from a report he wrote to a medical journal based on his experience of the benefits of music therapy as his primary treatment in mental health care for one-and-a-half years. He refused medication throughout the whole period; this was accepted by his psychiatrist. The report was written three years after music therapy was terminated:

> "Although music therapy officially has ended, I feel that it is still going on. All the experiments, notes and themes that I played out in the music, I now use in different encounters with other people, and it gives me a great feeling of freedom; freedom understood in the way that I have many different keys to play in – many different ways to tackle situations" (Wigram, Pedersen & Bonde 2002: 168).

A music therapist in this fourth phase, phase D, is needed to encourage, to mirror and to challenge the patient (beyond comfort zones) and to be a stable interplaying partner. Music therapists in this phase may have to move from a position of being a more supportive mother figure to being a more challenging father figure.

The last phase, a phase which for some patients means a *phase to learn to live with mental challenges outside the mental health system*, phase E includes the process of being an equal part of coherence in life (family, friends, society etc.). Here the interplay with other partners is in focus. Music can be a language for the former user of the mental health system to steadily be in contact with both inner resources and challenges. The same patient also wrote the following:

> "About three years have gone by since the music therapy ended – I still do voice exercises to become aware of how I feel right now, deep inside.

> This is a good tool for me to relax knots and tensions that are forming" (Wigram, Pedersen & Bonde 2002: 168).

In most cases a music therapist is no longer needed as the core person in this phase. The music therapist is not indispensable but may be the important link to other interplaying partners. The music therapy case experiences can be kept alive as internalised experiences – as supportive memories by the former mental health patient.

Music therapy – in spite of low motivation

People in this last phase, when suffering chronic mental health problems including those who experience negative symptoms of schizophrenia (such as low motivation to participate in life activities), can still benefit very much from music therapy as an offer of timely encouragement and possibly a vitalising quality of life (Gold et al. 2013). At the moment, we, the staff at the Music Therapy Clinic at Aalborg University Hospital (regarding the area of psychiatry) are working on a randomised, controlled, double-blinded national inquiry (comprising approximately 120 participants) on the effect of music therapy towards negative symptoms for people suffering from schizophrenia (Pedersen 2015). The study is carried out together with head doctors at the Centre for Psychosis Research. To apply such a challenging design in the inquiry is a demand from the health system to hopefully have music therapy recognised and listed as a part of standard care for this population. Our experiences from the study suggest that the biggest challenge is to recruit the participants. This is because either they automatically refuse to enter new challenges and cannot face the idea of attending 25 weekly sessions of music therapy, or their contact persons think that they are not able to manage such challenges. When the participants come to start music therapy, they mostly attend all 25 sessions and express their enthusiasm of being part of this project.

I think music therapy should be a part of standard care for many more populations in mental health care.

Flower figures of *'Why music?'* and *'Why and when is a music therapist needed?'*

I have tried to collect the different perspectives on *'Why music in mental health?'* in the form of a flower figure, as I do think music therapy is a flourishing and vitalising offer in the mental health system (Figure 1).

For most people it is obvious why patients are referred to physiotherapy (problems with the body) or verbal psychotherapy (psychological problems), but why is music therapy needed? From the examples presented here, I think music therapy is needed when patients have problems with verbal communication, with low self-esteem, identity and poor contact to the body and difficulties in entering spiritual experiences. Music therapy is offering relational meetings in a span between early nonverbal communication and spiritual self-experiences (Figure 2).

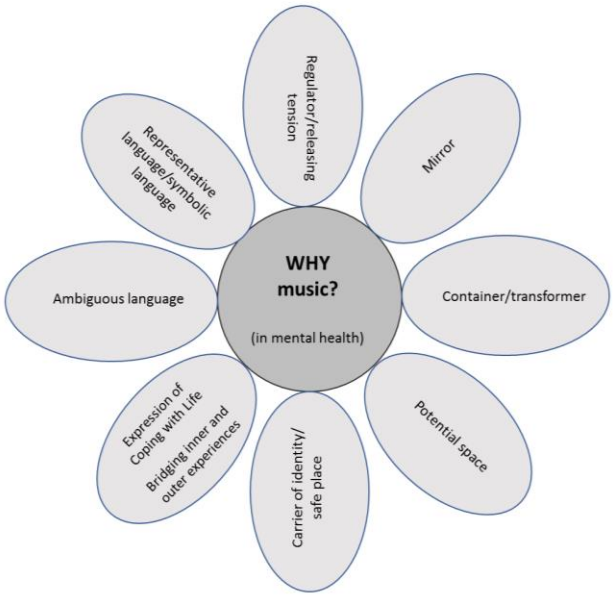

Figure 1: Flower of music

I have also collected my perspectives on *'Why and when music therapists are needed in the mental health system?'* in the form of a flower.

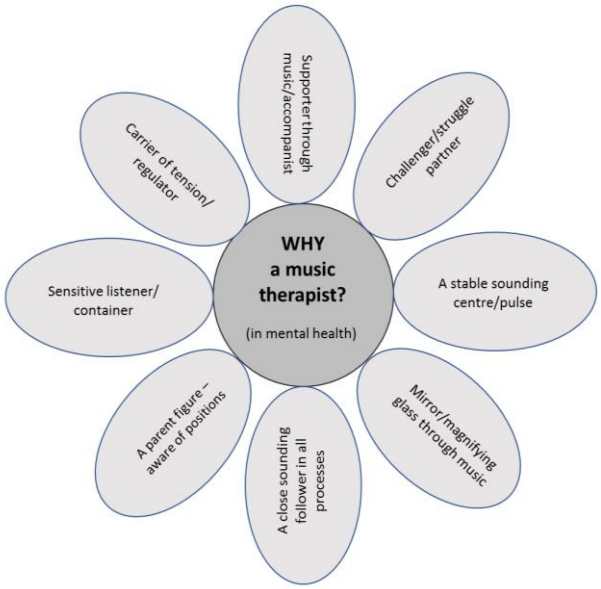

Figure 2: Flower of music therapists

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Lecture 2

‘Songs for life’ – A group songwriting research study for participants living with severe mental illness

Denise Grocke

University of Melbourne, Australia

From the time of the great Greek philosophers, music has been recognised for its therapeutic applications. Plato believed that

> “[...] rhythm and harmony find their way to the inmost soul and take strongest hold upon it (the soul) […] imparting grace […] to foster its growth” (Hamilton & Cairns 1961: 646).

Music provides an alternative means of communication to verbal language, it can be a means of expression of emotions that are difficult to articulate, and can bypass the need for cognitive organisation of thought. This is important for many of our participants who have difficulty in managing emotions, and processing cognitive concepts.

Music is ubiquitous; we can sing music, play music, listen to music deeply, and dance or move to it. We may create and compose our own music. The basic elements of music (rhythm, melody, harmony and dynamics (light and shade)) create a musical architecture on which we build these music experiences. As music therapists, we enable these experiences for people in the community who are the most vulnerable due to physical or mental health challenges.

In recent years, meta-analyses of controlled studies have confirmed the efficacy of music therapy for people with schizophrenia and similar illnesses, and for depression. A Cochrane review demonstrated that music therapy can increase motivation, social functioning, and global state in persons with severe mental illnesses with greater effect when 20 or more sessions are provided (Mössler et al. 2011). Similarly, individual music therapy comprising ten to 20 sessions has been shown to improve symptoms of depression and anxiety, and to enhance general functioning (Erkkilä et al. 2011).

People who are living with severe mental illness are often subjected to stigmatised attitudes, resulting in social isolation that curtails recovery. We know that singing in groups enhances quality of life, reduces stress and increases emotional wellbeing (Clark & Harding 2012; Clift et al. 2008). Anyone who sings in a community choir will have experienced that first hand.

It follows that, when we as music therapists offer music experiences (particularly singing original songs) with people who have severe mental illness, we offer a modality that enables participants to experience the same benefits, and to express their emotions through lyrics and music. As one participant in our research study (to be described below) said:

> Singing brings joy to the heart and the mind, you know.

Songwriting is recognised as an effective and compelling form of music therapy, whether applied to individual sessions with clients or with groups. Within the group context, songwriting calls on the music therapist’s skill to harness ideas for themes and lyrical content and to facilitate decisions about the musical structure of the song (including stylistic features and elements of melody, harmony and rhythm), alongside therapeutic skill required to make the group experience rehabilitative (Baker 2015; Baker & Wigram 2005).

When music therapists use songwriting in groups they draw on the potential of music to enhance socialisation. Research participants in a songwriting study (Grocke et al. 2014) valued this particular aspect and commented about the final product (the song):

> B: I enjoyed the collaborative part of it: Working together with other people to create something... the creative part of it was to actually write a song.
>
> H: It was good because we all had an input, so that made it (the song) ours. Our song and a team effort, we all had something in the song. You feel good if you’re in a team and you’ve contributed too. It’s given me more confidence to try new things.

L: I'd like to say that it gave me a new lease on life.

'Songs for life' study

The 'Songs for life' study was funded by an Australian Research Council Discovery Grant (Grocke et al. 2014). The research group investigated whether group music therapy positively impacted on quality of life, social enrichment, self-esteem, spirituality and psychiatric symptoms of participants with severe mental illness, defined as an enduring illness of more than a duration of two years. A qualitative component of the study explored their experiences of group songwriting through focus group interviews and song lyric analysis.

Ninety-nine adults (of whom 57 were female) were recruited, with participants randomised to either: weekly group music therapy (over 13 weeks) followed by standard care; or standard care (for 13 weeks) followed by group music therapy. The music therapy group comprised writing the lyrics for the song, and contributing to the music architecture of the song – the genre, major-minor key, ascending or descending melody line etc. In week 12, the songs for each group were recorded in a professional studio and copies of the CD given to participants at the focus group interview, conducted in week 13. There were 13 groups of four to six members. Results showed a significant difference between group music therapy and standard care on quality of life (p=0.019, with a moderate effect size (d=0.47) and spirituality (p=0.026, with a moderate effect size (d=0.33), with greater benefit for those receiving more sessions. Moderate effects of group music therapy for global severity of illness (BSI) (d=0.36) and self-esteem (d=0.35) were found, but did not reach statistical significance (p=0.061 and p=0.054 respectively).

Focus group interview and song lyric analyses suggested that group music therapy was enjoyable; self-esteem was enhanced; participants appreciated therapists and peers; and although challenges were experienced, the programme was unanimously recommended to others.

Why and when is a music therapist needed?

In order to respond to the question of why and when a music therapist is needed, I will draw on the comments offered during the focus group interviews, as they illustrate and describe what the participants noticed about the music therapists.

The focus group questions were very broad as we did not want to influence what the participants said. The questions were also balanced drawing out both positive and negative experiences of the group songwriting project. The questions in part were:

1. What did you like about the project 'Songs for life'?
2. What didn't you like?
3. What was it like to write a song in a group?
4. Were there aspects you didn't like?
5. Would you recommend this project to others?

Theme 1: What was liked: Accomplishment and satisfaction

N: It was a very positive experience… what I did like, was extending myself… and a sense of accomplishment, doing something that you've never done before. I wouldn't be able to do this on my own.

KS: I just enjoyed being around people who were positive and really happy and willing to take part. There was a good energy with everyone… and a feeling of satisfaction afterwards that we achieved what we set out to do.

AN: I found it to be a very positive experience. I was able to put in words some of the innermost feelings, which normally I would keep hidden. In the song I was able to express some feelings not only I have myself but a lot of other people, I believe, experience as well.

Theme 2: Reclaiming a love of music

Group music therapy also enabled participants to reclaim their love of music:

J: I always wanted to be a musician, and I didn't know how good I was till I heard myself.

D: It was fun making the CD and now I've got proof that I can sing really well.

H: It was great being in the group. I enjoyed the singing and trying to play the instruments... I enjoyed it more than I thought I would.

J: The sessions proved to be a great creative outlet, a means for self-expression and an opportunity for me to focus on more positive things in life, such as music.

T: I think [singing] gives you more confidence. Singing is something that I don't think people are particularly encouraged to do. I think we listen but we don't participate in music, and so it builds your confidence that you can actually participate in it.

J: I just love singing. I mean, I've never been a professional singer, but I've come from a family that sings all the time and I've been brought up with music and I just love it. It's very therapeutic.

Theme 3: Qualities of the music therapists

We did not ask the participants any questions specifically about the music therapists themselves, however the following comments were made spontaneously in answer to the question what they liked about the programme.

J: I liked working with the other group members and I thought Jason was a great music therapist, caring, engaging and talented.

D: Damien and Janet [the name of the therapists] were really good. They didn't put any pressure. So we could come out with the best stuff, you know. Just really supportive. When you're stressed too much you can't be creative if somebody's dominating, and saying you must do this, then you're not very creative.

H: I'm stunned that it came together so well. I'm a bit stunned how that happened, you know. I try and write words and bits and pieces and everything, but Lucy encouraged you and supported you in the way that you needed, and made me think, because she wanted some input from everybody, not just me. I mean, she did the same to everybody. It was really good listening to her sing, she's got a really good voice, and she conducted it that we all had input, you know what I mean, and it wasn't necessarily one person taking over, you know, you got your fair share.

Je: I think the music helps you, um, makes things clearer and it helps you get your thoughts out better. And I want to say Jason was very good... professional. I said to my doctor he was very good because he included everybody and he included everybody's ideas and made everybody feel valued and worthwhile... and that was a big thing... and the end result is something very special.

P: I think Emelia gave us space to do our own thing... she didn't pressurise us into playing it a certain way or singing it a certain way. I think she gave us leeway for our own creative belief.

Al: I got to use the voice, you know, and to sing around the house. I got to drum and sing and Emelia was wonderful and supportive, and she gave space and, um, made it fun even if you were having a bad day – I appreciated that.

P: And there was an acceptance. You know, we didn't have to put on anything because everyone accepted each for who we were.

V: (tearfully) I felt a part of a family here (in music). Emelia was very approachable and down to earth, and I don't know what the word is – open-minded?

P: We couldn't have done it without her.

Theme 4: What was not liked

Aspects that were not liked in the project included that a one-hour session was too short, and a 13-week project was too short, and that there was nothing at the end of the project to enable participants to continue their singing.

Participants commented they would have liked the music group sessions to be held in a neutral place, like a church hall, instead of at the clinic, where they are reminded of medication and difficult questions from the case managers. They wanted a creative space for their songwriting. Participants also were sometimes daunted by their experience recording the song in a studio.

Reprise: Why and when is a music therapist needed?

In summary, the qualities of the music therapists appreciated by the participants included that they were caring, supportive, encouraging, engaging, and wanting input from everyone, making people feel valued and worthwhile, giving leeway for each person's creativity, being open-minded, and accepting each person for who they were. While many of these qualities can be found in musicians who are sensitive to others, music therapy training instils the importance of drawing out members of a group who are not contributing, by encouraging them to make a contribution so that they feel valued. This requires skill and the ability to wait, to be comfortable in silence, and to create an open

space that allows time for reflection.

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Reflection paper

Why music? Why and when is a music therapist needed in mental health care? What have we learnt?

Niels Hannibal

Aalborg University, Denmark

Background

After the symposium at Temple University in April 2015, I thought there was a need for taking this shared process a step deeper or to take it in a slightly different direction. My idea of suggesting the targeted topic of '*Why music? Why and when is a music therapist needed?'* for the next symposium at Aalborg University in April 2016, was to invite presentations of thoughts and rationales about why music is a good intervention in a therapeutic context, and why we need a music therapist to administer the intervention. My view was, and still is, that explaining this to ourselves as a profession and, more importantly, explaining it to interdisciplinary teams, to politicians and to clients and users of music therapy, has been an ongoing agenda and struggle for a long time. We need to be more expressive and clear in our communication with the non-music therapy community. The diversity and complexity of music therapy makes this kind of thinking a huge challenge. The idea was to invite some of the 'state of the art' thinkers in music therapy, and give them an opportunity to present their thoughts and most recent knowledge within the topics.

In the invitation letter, the task for the presenters was described as follows: to present arguments and explanations as to why music is an agent in the chosen clinical area, and why a music therapist is required. My expectations of this day were huge. I fantasised that hopefully we would now be able to explain much clearer and precise, what is the rationale for using music and for the need of a

music therapist. So what happened and what answers did we get in this roundtable?

The answers

The obvious learning from the roundtable and overall from the day was two things: 1) there are many more ways to address these questions than I had imagined, and 2) we are far away from a unified rationale as to why music and why and when a music therapist is needed. I will now reflect on these two statements.

There are many ways to address these questions. They may, for example, be seen as a claim – i.e. we *claim* that music and a music therapist *are* needed. That is implicit in the topic. Music therapy researchers are there to support this statement. Moreover, in order to do so we, as academics, have different options; we can refer to research, to theory, to case material or a combination of these.

Pedersen gave a theoretically-focused presentation even though she also referred to RCT studies and meta-analysis. When addressing the issue of why music, she used Bonde's writings (Bonde 2002, 2011, 2014). She presented music "characterised as an ambiguous, representative, symbolical language" as a rationale for using it in mental health. This is how music differs from verbal language and how it provides different options for mental health patients. When addressing the topic of the music therapist she used her own writings as a basis for describing a rationale for music therapy with this population. Pedersen has made some very important contributions over the years. Her presentation revealed how complex it is to describe what is important in a therapeutic endeavour and, in a way, it showed why answering the questions as to why music and why and when a music therapist is needed are not so straightforward. We can even answer these questions by referring to research and/or by using a more theoretical-based rationale and/or by describing the process of music therapy in a case-focused perspective.

Grocke referred to research findings when talking about group music therapy and songwriting with a group of patients with severe mental health problems. This is a classic way of supporting the idea of music therapy (and indeed any other treatment for that matter). Grocke's presentation, however, does not offer a coherent rationale concerning the two core questions. The argument is that the research shows improvement and the participants express their appreciation for the treatment, and that in itself is a rationale. There may be obvious reasons for choosing such a strategy for the presentation; there is a time limit, and giving a more in-depth rationale for songwriting as a method in music therapy is a considerable task.

In his presentation, De Backer used a more theoretically-based approach in his argument. He talked about music as something beyond words. Something that at the same time is present in the preverbal interactional context of therapy and also in the personality of the therapist. The music therapist has a psychotherapeutic ego that *is* music. We meet the world from a musical position. According to De Backer, how the therapist thinks and feels about music influences the therapy even when there is no music being played. This also reflects his belief that all music therapists need to be musicians. Enhancing this music-focused perspective suggested a different way in which to build a rationale for why music and why a music therapist. What is unique about 'us' as a profession is the ability to express ourselves through music, to experience our self and the other through music, and the ability to listen, observe and respond in a relationship through music. De Backer advocated for more individual case studies in order to investigate interventions, and studies focusing on the music itself during treatment.

In that respect the presentations revealed that, in my view, a simple and clear rationale for why music and why a music therapist is needed is not easy to produce and not present in our thinking and talking about music therapy in mental health.

As presented here, there are many different ways to address these questions and we listened to very different ways of handling this challenge. All presentations were based on research and some on theory and clinical experience. There was not, however, one unifying understanding; perhaps there will never be such a unified rationale.

This leads me to the second part of my answer. We are, as stated, far away from a unified rationale for music therapy. Yet stating this based on the presentations from this afternoon is unjust. There are intense writings and thinking about why music is a good idea in mental health care and why a music therapist is needed. After the presentations, however, I have come to realise that we might be asking the wrong questions.You would never

investigate the rationale for psychotherapy by asking the question '*Why applying words?'* It makes no sense to simply focus on language itself in order to understand the process of psychotherapy. Words are, of course there; how else can someone convey how they feel or what they think? My point here is that what is difficult for politicians, for example, to understand is how music can convey anything other than aesthetic beauty and perhaps some pleasure and distraction. There is a lack of an understanding and appreciation of what music 'brings to the table' that has therapeutic value. This raises the question if talking about music itself, as something that stands alone, makes more sense than talking about words. My own initial thought was, in a sense, doomed.

I believe that we, as music therapists, possess knowledge about music in a therapeutic context that is based on self-experience as clients and on clinical experience as therapists. We have knowledge that, to some degree, is implicit and beyond verbal language. We know what playing with someone is like. We know, for example, how writing a song can empower you and how listening to music can influence your state of mind. This is what I call a deeper understanding. In order to build a solid rationale for music in music therapy and the need for a skilled music therapist, I believe that we need to address this deeper understanding which we, as music therapists, possess and which makes great sense to us when engaged in conducting the process of treatment.

Another important issue is founded in the idea or notion that it is possible to talk about and describe music therapy from one model. It would, referring back to my word analogy, be equal to postulate that it is possible to make one rationale for using language in treatment. No one would ever try to do that. Language can be used as an agent in many different ways: to enquire, to support, to explore, to negotiate, to argue, to understand, to make fun etc. We know this. We do not need to say it. But it is not clear when it comes to music. My point is that a rationale for using music in therapy must focus on what we use it *for* – i.e. the function and the purpose of the intervention. What do we want to achieve by the interventions we perform? Do we want to build relationships with the other person through music? Is it to provide opportunity for self-expression and self-exploration? Or do we want to help regulate internal states? Do we want to form and build new identity and self-perception? This way of talking about *why music* must include a purpose. There is a reason for doing it and it is related to the needs and problems of the client in front of us. When that becomes clear, the need for a trained music therapist in contrast to a skilled musician becomes obvious.

In my humble opinion any rationale for applying music is connected to the therapeutic situation and the needs of the client. And these differ. This is also mentioned in the Postlude by Bonde. He stated in his concluding comments the following: there do not seem to be a few simple common answers to the questions; there are many good and possible answers to the questions within the specific clinical areas; and they are always influenced by who you ask and in what context.

Diversity and complexity were also reflected in the discussion following the presentations. These included issues such as how we talk about music, how we describe what music does and the different ways music can be used in relation to different phases in treatment. We also considered whether music therapy was 'only' about music, or also words or art and so on. Finally, questions of how to talk about mental illness were also introduced.

The presentations and the discussion both revealed that music therapy research supports the *why* questions. Yet we have not found a way to talk about music in music therapy that can be described as one rationale for using music and for needing a music therapist. I do not think we ever will. I think we need to focus on the needs of users who we, as music therapists, aim to help, more than focusing on the element of music itself. Having said that I think there is a great need for more theory and rationale for why music in the hands of a music therapist can, for example, establish a relationship with an isolated person, help regulate arousal, form identity and self-perception, help build group cohesion and heal trauma.

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PART TWO: MUSIC THERAPY IN DEMENTIA CARE AND NEURO-REHABILITATION

Roundtable presenters
Ridder, Odell-Miller, Schmid

Discussion group members
Beck, Fachner, Dileo

Moderator: Stige

A reflexive introduction

The many futures of music therapy in dementia care and neuro-rehabilitation

Brynjulf Stige
University of Bergen, Norway

With the radical shifts in the demography of most societies in the world today, debates emerge about the needs and rights of the growing number of people living with dementia. Increasingly, music therapy is part of these debates, and its relevance within neuro-rehabilitation seems to be developing as well. When Aalborg University held a symposium titled *'Music therapy: A profession for the future'* on 15th April 2016, the fields of dementia care and neuro-rehabilitation naturally were on the agenda.

In the symposium in Aalborg, three music therapy specialists presented their visions about the questions '*Why music?'*, *and 'Why and when is a music therapist needed?'*. These are documented here in three lecture papers by Hanne Mette Ridder (Denmark), Helen Odell-Miller (United Kingdom), and Wolfgang Schmid (Norway). The roundtable discussion following the presentations at the symposium had input from Bolette Daniels Beck (Denmark), Jörg Fachner (United Kingdom), and Cheryl Dileo (USA). A plenary discussion followed after that. The present reflexive paper introduces lecture papers that subsequently have been developed by Ridder, Odell-Miller, and Schmid, and also a reflection paper from another perspective by Beck. In addition, the introduction is inspired by the verbal discussions at the symposium in Aalborg.

Three lecture papers and a further reflection paper

In her lecture paper on music and music therapy in dementia care, Hanne Mette Ridder (2017) outlines several responses to the question of why music for persons with dementia. Some of these are medical

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in nature, informed by new knowledge on the brain mechanisms supporting the processing of musical information. Ridder supplements her presentation of this with references to qualitative research exploring the experiences of persons living with dementia, as well as the experiences of families and staff. The medical model does not suffice in responding to this question; indeed Ridder argues that there is also a need for a psychosocial model of music in dementia. This appraisal informs her response to the question of why and when a music therapist is needed; she strongly argues in favour of cross-professional work and a broad and flexible role for the music therapist, including practices of knowledge exchange and collaborative knowledge mobilisation.

Helen Odell-Miller (2017) also writes about music therapy in dementia care, and she argues that the music therapist's unique role in dementia care is where specific needs for people with dementia, including their carers, cannot be met by others. In qualifying the claim, she offers as an example how music therapists can support and enhance non-verbal communication with people with behavioural and psychological disturbances in the advanced stages of dementia. She then outlines research, theory and clinical experiences that support this appraisal. Similar to Ridder, Odell-Miller underlines the value of working with people in addition to the patients themselves, such as families and carers, who might need supervision and support. Odell-Miller relates the prioritisation of tasks to the various stages of dementia.

Wolfgang Schmid's (2017) lecture paper focuses on improvisational music therapy in neuro-rehabilitation. After a brief overview of the literature that documents the increased interest in music therapy and neuro-rehabilitation, he outlines an argument that includes and goes beyond the knowledge produced by neurology and neuroscience. The benefits of music therapy must be explored musically in relation to each person's needs and possibilities in context, Schmid argues. He also argues that we should not only take interest in why and when music therapists are needed. We should also invert such questions and examine the limitations of the profession and possible contra-indications of music.

In her reflection paper, Bolette Daniels Beck (2017) concentrates on music therapy for prevention of stress and mild cognitive impairment. Beck examines literature on the relationship between the amount of life stress and the onset of dementia or mild cognitive impairment. After reviewing the literature, she concludes that there are many benefits of music listening and music engagement for prevention of stress and mild cognitive impairment. She therefore argues that people's possibilities for active engagement with music is a public health issue and that music activities should be widely supported in schools, institutions, hospitals and local communities.

Comments and reflections

The three lecture papers and the further reflection paper presented above were – as already mentioned – part of a symposium where Jörg Fachner and Cheryl Dileo also participated in the roundtable discussion, followed by a plenary discussion. We could consider this as part of ongoing reflections on the future of the discipline and profession of music therapy (Dileo 2016). In the discussions, some highlighted neuroscientific and medical knowledge supporting music therapy interventions, others argued for a more psychosocial and sociocultural approach to the study and practice of music therapy.

Jörg Fachner, who previously has written several texts on how musical responses can be measured (e.g. Fachner 2016), contributed in the discussions with a commentary where he argued for the importance of using biomarkers to support case studies (see also Ridder & Fachner 2016). Fachner argued that it is important to use an objective measure that can be contrasted to the subjective data that music therapists often collect. Biodata cannot be manipulated while recording and therefore have many strengths, Fachner argued, although he admitted that interpretation and application is often very difficult. As a comment on how research methods can be improved, he talked about the importance of using technology that is as non-intrusive as possible, and he reflected on the possibility of a future where music therapists are much more proficient than today in integrating mobile brain-body measurement tools into the lifeworld of the clients and our music therapy practices.

The many futures of music therapy

Obviously, there are many futures of music therapy. The papers and commentaries referred to above not only refer to different aspects of our future, they also reflect different visions of it. This should come as no surprise if one considers the multiple histories of music therapy, informed by a number of diverse theoretical perspectives, such as medical, behavioural, psychodynamic, humanistic, transpersonal, culture-centred, and music-centred perspectives (Bunt & Stige 2014). To develop agreement about what perspectives could best serve the future of the discipline and profession would hardly be a realistic ambition for a symposium, and I did not observe any attempts in that direction either.

At the same time, the discussions did go beyond sharing recent developments in theory, research and practice. Several of the contributions highlighted a personalised and contextualised approach to music therapy where personhood as well as the social context of practice, were taken into consideration. Perhaps – in the midst of the multiple futures of the profession – there will be possibilities for shared concerns about the need to tailor practices to person, place and time. This is hardly a new idea in music therapy, but new and broader ways of practising seem to be developing; for instance, when music therapists prioritise to work with families and staff, to care for the sound environment of homes and institutions, and to promote patients' rights as citizens (Stige & Ridder 2016).

Obviously, such visions do not invalidate the medical and neuroscientific knowledge on music, and the question remains as to if and how it will be feasible to integrate and/or flexibly apply several theoretical perspectives in the development of profession and practice. The future of music therapy will not only reflect developments in theory, research and practice, but values-based prioritisations of our limited time and resources as well. Our capacity to listen will be key.

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Lecture 1

Music therapy in dementia care and neuro-rehabilitation

Hanne Mette Ridder
Aalborg University, Denmark

A video clip posted by the Los Angeles Times shows a woman lying in a hospital bed (Simmons 2013). Beside her bed sits a young nurse. He is holding her hand in both of his – and he is singing for her. She looks at him, her lips are moving with some of the words and a smile comes to her face. Then she turns her head away and wipes away a tear, clearly moved by his singing.

The patient, Norma Laskose, who is 89 years old and suffers from pneumonia and lung cancer, explains that "When he looks at you, you know that he is singing *to* you. It just pierces my heart". She is not a dementia patient but the video shows how this "singing nurse" is offering a special method to keep the patients' minds off their pain. Nurse Jared Axen of Valencia Hospital in California sings to soothe his patients. His talent was discovered at the hospital by chance (Simmons 2013, para 4). Through casual singing when he was working, Axen realised the positive effect of singing and understood that this was a unique way to connect with his patients. For his important work, Axen was awarded Nurse of The Year in 2012, and also received The Southern California Hospital Hero Award in the same year. Similarly to California, nurses and health professionals in many other countries have described how they use singing or music as a way to contact patients and to create moments of powerful, passionate and intense contact. This awareness to use music in the care of patients seems to have increased in recent years which is exemplified through websites, television broadcasts and YouTube clips from, for example, Australia[1], Norway[2], Sweden[3] and the USA[4,5].

Why music for persons with dementia?

In line with the increasing interest in applying music in medical care, the healing power of music has been recently highlighted in journals such as the *Scientific American* (Thompson & Schlaug 2015) and *Musicae Scientiae* (Croom 2015). In an article published in the journal *Nature*, the "surprising preservation of musical memory" in persons with Alzheimer's Disease is explained (Jacobsen et al. 2015: 2439). In discussing these findings of musical memory in relation to music emotion and auditory processing, Clark and Warren (2015) argue that we urgently need to re-evaluate what we know about dementia by integrating new understandings of how brain mechanisms support musical information processing. This may bring us new and powerful methods in treatment and care.

> "The conundrum of Alzheimer's disease may finally be solved only once we understand its more subtle and least tractable effects, which are frequently the effects that matter most to our patients. Music may be a means to achieving this end" (Clark & Warren 2015: 2125).

Indeed, Alzheimer's disease and dementia generally present us with a conundrum. In numbers alone, we are challenged with close to eight million new cases each year, resulting in almost 50 million people living with symptoms of dementia (WHO 2015). Dementia is a syndrome leading to neurodegeneration increasingly affecting the person's thinking, behaviour, memory and activities of daily living. Consequently, dementia is one of the major causes of disability and dependency among older people and therefore has great impact on

[1] ABCnet 2016: http://www.abc.net.au/catalyst/stories/4421003.htm

[2] NRK 2014: http://www.nrk.no/livsstil/nrk-helene_-_-noe-av-det-sterkeste-jeg-har-opplevd-1.11990203

[3] Wahlgren 2016: http://singingnurse.se/

[4] Trailer, Alive Inside: https://www.youtube.com/watch?v=IaB5Egej0TQ

[5] SparrowTV 2016: http://sparrowtv.org/videos/sparrows-singing-nurse-linda-porter/#.WBDymKKfbvN

everyday life for the person and also for the family, for health professionals and for society as a whole (WHO 2015).

The meaning and value of music for people with dementia was explored in a qualitative study by McDermott, Orrell and Ridder (2014) with a focus on how music is experienced from the perspective of people with dementia themselves, and also from the perspectives of families, care home staff and music therapists. This led to suggesting that music taps into an individual's sense of self in relation to personal preferences and life history, and goes beyond the idea of music as a tool to fix behavioural problems (McDermott et al. 2014). Music is understood to be part of a wider appreciation of life which may be explained in the paper *'Psychosocial Model of Music in Dementia'* (McDermott et al. 2014). This model integrates an understanding of music experienced by people with dementia with regard to 'who you are' and the 'here and now' and with musical and interpersonal 'connectedness'.

Why and when a music therapist?

Music therapists are trained to tailor the use of music to the aims of each individual client and to meet psychosocial needs at various levels. In music therapy sessions, the therapist is aware of how to compensate for neurodegeneration in the person with dementia by applying a variety of positive interactions (Kitwood 1997). These interactions may encompass music in order to:

1. catch attention and create a safe setting;
2. regulate arousal level to a point of self-regulation;
3. engage in social communication in order to fulfil psychosocial needs (Ridder 2003, 2011; Ridder & Wheeler 2015).

The above clinical approach was applied in two recent randomised controlled trials that showed the positive effect of music therapy on neuropsychiatric symptoms in people with dementia (Hsu et al. 2015; Ridder, Stige, Qvale & Gold 2013). However, the latest updated Cochrane Review on music therapy for people with dementia (Vink, Bruinsma Manon & Scholten Rob 2011) could only include ten studies, all of which did not satisfy the quality to be included in a meta-review. It is therefore not (yet) possible to claim that there is evidence for music therapy; however, a number of review studies on non-pharmacological interventions suggest a positive effect of music or music therapy on agitation (Hulme et al. 2010; Kverno, Black, Nolan & Rabins 2009; Livingston et al. 2014; McDermott, Crellin, Ridder & Orrell 2013b; Spiro 2010; Ueda, Suzukamo, Sato & Izumi 2013; Wall & Duffy 2010). Among these, the health technology assessment by Livingston et al. (2014) included 160 studies of sensory, psychological and behavioural interventions for managing agitation in older adults with dementia. From this vast material the researchers concluded that the following five interventions reduce agitation in care home dementia residents: person-centred care, communication skills and Dementia Care Mapping (all with supervision) as well as sensory therapy activities and structured music therapies. Furthermore, the researchers added that future interventions should change care home culture through staff training.

Discussion: interdisciplinarity and knowledge mobilisation

Music and singing is increasingly used in healthcare and for people with dementia – with good results – although the evidence of the effect of music therapy in dementia care is not confirmed in a Cochrane review. All health professionals who have the courage to explore non-pharmacological or psychosocial approaches to meet their patients' needs should, like Axen, be rewarded for their innovative approach. However, we can do better than leaving it to individual health professionals to develop such approaches by coincidence. Music therapists are trained to explore the application of music for the needs of individual persons. By being used as consultants at hospitals or nursing homes, music therapists can inspire, guide or teach health professionals or caregivers in a more systematic way, providing them with specific methods and techniques for the use of music.

In more complex cases, the person with dementia should be referred to music therapy treatment. As soon as it is appropriate, however, the music therapist should work together with the team around the respective person in order to share the knowledge gained in the therapy to help them make use of this in daily care and activities. This interdisciplinary approach to dementia care will increase knowledge mobilisation and knowledge

sharing, and pave the way for new learning for all involved, not least for the person with dementia. In this way music is integrated in the interaction between:

- ❑ person with dementia and music therapist;
- ❑ person with dementia and caregiver;
- ❑ person with dementia and the culture of care.

In this way we may distinguish between direct and indirect music therapy practice (Bunt & Stige 2014; Sandve & Enge 2015). In some events change may only occur through a direct therapeutic interaction. This does not make it less important, however, for the music therapist to pull back when the time is right and to leave his or her place in the interaction to the caregiver (either professional or a relative). The goal is to repair and strengthen the interaction between the person with dementia and the caregiver in order to influence the culture of care in the most positive way.

Following this, direct music therapy practice will consist of:

1. music therapy treatment based on referral, assessment and documented work, carried out by credentialed music therapists;

Expert knowledge integrating theory, practice and research – and the indirect music therapy practice will consist of:

2. knowledge exchange between the music therapist, person with dementia and caregivers;
3. knowledge mobilisation where the music therapist shares his/her expert knowledge – e.g. by teaching and supervising;
4. the music therapist's initiation, coordination and/or supervision of music activities provided by caregivers or community musicians.

Conclusion

The common goal for the dementia field is to advance and develop the culture of care. The music therapist may engage directly with the person with dementia through a music therapeutic intervention, or may assist other healthcare professionals, relatives or musicians in providing musical activities to build a relationship with the person with dementia, and on the terms of each person with dementia. It is complicated to interact through mutual understanding with persons who are difficult to engage due to neurodegeneration, but if this is done with insight and knowledge we might see important and beneficial 'side effects', such as increased quality of life, less agitation and restraints, and a reduction in psychotropic medication. Music therapists, who play a role in staff training and supervision, and not only in direct music therapy practice, bring new important dimensions to how music therapy discipline is understood and how it is integrated in interdisciplinary work.

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Lecture 2

Music therapy in dementia care and neuro-rehabilitation

Helen Odell-Miller

Anglia Ruskin University, United Kingdom

In this short lecture paper, the unique specific interventions of a music therapist in the field of dementia will be discussed within the context of clinical practice, research and education. This is a crucial topic because in 2016 approximately 55.4 million people were reported to be living with dementia worldwide. This is estimated to increase to 75.6 million in 2030, and 135.5 million in 2050. This results in an increased demand for long-term care in which effective management of symptoms is a major issue.

Clinical practice

The music therapist's unique role in dementia care is where specific needs for people with dementia, including their carers, cannot be met by others. In advanced stages of dementia, for example, cognitive decline leads to behavioural and psychological disturbance, and also confusion. Non-verbal communication through musical interaction is crucial at this stage, using improvised music where the music therapist supports, validates, recognises and musically develops the person's musical expression with them.

Behavioural and Psychological Symptoms of Dementia (BPSD) such as agitation, depression, apathy and anxiety are reported to affect approximately 80% of people with dementia living in care homes. In the dementia care environment, the music therapist is also needed to supervise others using music in everyday care which improves their communication and wellbeing (Hsu, Flowerdew, Parker, Fachner & Odell-Miller 2015).

Music therapy in this context is the systematic application of music within a therapeutic context for

therapeutic purpose, drawing upon live and receptive possibilities of music. This could include free improvisation, structured or unstructured. Individual and group sessions also draw upon composed or pre-composed music such as songs or songwriting, or receptive techniques involving listening to music. Thus the unique significance and function of the following qualities and potential for music in music therapy for people with dementia is important:

1. non-verbal possibilities;
2. use of all the senses;
3. artistic spontaneity and musical narrative;
4. physical, intellectual and emotional needs (music therapy does not always require conscious thought for the patient).

Stern's concept of synchrony is important as a theoretical model here, as Malloch and Trevarthen emphasise:

> "[…] there would be no way for me to sympathize with another person's intentions and feelings if we could not share the rhythms of this self-synchrony to establish inter-synchrony" (Malloch & Trevarthen 2009: 77).

When the person is in a state of self-synchrony, opportunities to establish inter-synchrony are possible (Malloch & Trevarthen 2009).

Cueing and social communication are impaired for a person in late-stage dementia. Through using live interactive musical improvisation, the music therapist can frame a safe environment with 'neuro-ception' and acoustic cueing. Such conditions are needed for the person with dementia to engage in social communication.

This is demonstrated by music therapy examples from M, a musician with early onset dementia (Odell-Miller 2002). In the third year of individual music therapy, held weekly in his home, M needed help with daily living skills. His speech was often confused, agitated, unintelligible, and he was in cognitive decline; he could still sense pitch, and musical form. His musical language within improvisations appeared intact during moment-to-moment phrases, accompanying the therapist singing, with musically coherent recitative-style chords. As the therapist, I was also able to work with M and his wife musically to help her communicate with him, and to provide emotional support. Music therapy clinical material in research studies shows how musical interventions are also effective for people with and without musical pre-skill, such as in our research study (Hsu et al. 2015).

Another clinical outcome through music therapy can be increasing happiness. Whilst this is important it is also crucial to stress the unique capacity for music therapy, delivered by a trained music therapist, to work with a whole range of emotions and feelings which could also include pain and distress. This is similar to verbal psychotherapy, which is not usually possible for people with dementia to access when in the final stages of dementia. Music therapy, therefore, is needed for this type of expressive process, and it is often a relief for this to be recognised for a person who cannot express happiness, frustration or sadness, for example, through words. Furthermore, Hsu (2015) was able to show that musical interaction using composed song can stimulate memory, laughter, movement and a sense of self.

Research

Scientific theories and emerging music and brain evidence also support the unique need for music therapy. When listening to music, several areas in the left and right hemisphere of the brain are involved in processing the various dimensions of music. For example, the auditory cortex within the temporal lobes is engaged in general auditory perception (such as pitch, intensity and duration), the basal ganglia and motor system for processing rhythm, and the amygdala for processing emotional aspects. All these phenomena make the specific intervention crucial as the latest music and brain research shows. As reported by music and brain specialists, a common observation for dementia clients is that certain songs seem to reactivate memory and cognitive functions, especially those songs with strong emotional connections (Cuddy 2005). Research on music and emotion shows involvement of the nucleus accumbens and amygdala, which triggers dopamine release supporting attention and memory (Fosha et al. 2009; Levitin 2006; Salimpoor et al. 2011). MRI evidence from semantic dementia indicates that the right temporal pole is correlated with remembering songs and the grade of deterioration. This indicates a definite neuroanatomical correlate between deterioration and the degree of musical knowledge

(Hsieh et al. 2012).

The clinical intervention in research studies is now applied more systematically, learning from what we know already. In Hsu et al.'s (2015) randomised controlled feasibility study, the use of a consistent individual music therapy framework for dementia – described also in Ridder et al. (2013) is presented – and similarly Odell-Miller (1995) showed the benefits of group music therapy interventions.

In summary, from the literature the following components are necessary: live improvised music using song and structured, directed instrumental work to meet identified aims for managing neuropsychiatric symptoms, including movement and walking; catching attention through shared musical improvisation, and creating a safe setting; regulating arousal level to a point of self-regulation, and social communication for psychosocial needs.

Music therapy as aforementioned is particularly helpful for reducing negative behaviour. The music therapist's specific role, as demonstrated in many settings in Hsu's et al. (2015) study, is to understand the general problems of the older person. Crucial in this model is the integration of music therapists with the multidisciplinary team or care staff. Music therapists show how music therapy can help meet clients' needs through video examples within music therapy sessions. Subsequently, care staff can use music and/or different ways of interacting – in between music therapy sessions – learned from the music therapists. One lady in our research study showed that her functioning abilities could be identified and promoted during music therapy sessions. Auditory and visual perception remained very sensitive and therefore she was able to adjust her music playing or bodily expressions according to the volume, intensity and dynamics of the therapist's musical input as well as the therapist's facial, vocal and bodily expressions. It was noticed over five months of music therapy that she seemed to be increasingly able to use words to respond to the therapist. She also used more complete and consistent phrases in answer to questions.

An example of the need for a music therapist's input to the general needs of another resident N are shown as follows:

- Familiar songs with familiar musical structures engage N, and motivate her to participate in musical activities, often playfully with a sense of fun. She displays a visible reduction in anxiety and agitation during sessions, and an increase in positive affect.
- Prompting and encouraging N to play the piano helps her to use and reconnect with her remaining abilities; this also encourages memory retrieval of childhood memories.
- Matching N's rhythm and pace, and then slowing down encourages N to play and interact at a slower, calmer pace. This helps to reduce her anxiety levels.
- Reading the lyrics in music books together helps N to make use of her remaining cognitive abilities, and also helps her to focus and engage in a shared activity, helping her to feel calmer and less anxious (Hsu et al. 2015).

Music therapy reduced negative behaviours for those who had music therapy. The behaviours reduced by half, mostly in the first three months, and continued to fall after the sessions were completed. In contrast, negative behaviours in those who did not have the therapy increased – again this is common in more advanced dementia. Music therapy was also seen in clinical examples to lift mood as a result of the music therapist playing upbeat music in sessions, when appropriate. Medication use in some studies (Hsu et al. 2015; Ridder et al. 2013) is also shown to decrease for recipients receiving music therapy, more than for those not receiving music therapy. This is another strong indication of how music therapy is needed for relaxation and reduction of agitation.

Care staff involvement in the research project included the music therapist/researcher showing three-minute video clips from music therapy sessions of meaningful moments to the staff. Staff then used musical elements that were effective, involving singing, rhythmic interaction and listening. Suggestions for carers' interventions between sessions, in their daily routine, were also drawn up by the music therapists. These included the following examples:

- N can become out of breath easily, which can make her feel more anxious. When she is walking around the lounge she can become breathless. Getting her to sit down in her bedroom or the quiet room could help reduce her agitation. Sitting at the piano with her can help to relax and engage her. Focusing on

singing or playing together can draw her attention away from her anxiety and help her to feel calmer.

- N enjoys picture-books but has little motivation to look at them when sitting alone. Sitting next to her and prompting her to read a book can help motivate her to participate in this activity, and sustain her attention for longer. This latter point arose from the observations of how sitting alongside N in music therapy sessions sharing instruments helped her.

In the United Kingdom and some other countries, music and other arts activities which include music therapy are now indicated as important in national guidelines for people with dementia. Relatives and carers need to know they can have access to therapies and activities which do not require complex cognitive powers but which focus upon positive non-verbal interaction which is usually possible even in the last stages of dementia. There should be choice and opportunity for people to access arts-based activities and arts therapies, especially where there is evidence of efficacy as presented in the few examples of research studies above. Music therapy is also useful for people who do not have English as their first language.

Education

It is essential to consider specific dementia awareness training for health and social care staff such as is currently delivered regularly in the United Kingdom. What appears to be missing from some of these programmes, however, is an emphasis on how to communicate through sensory, art-based media, music and other arts therapies; these could be integral to such training. Current research (Hsu et al. 2015) mentioned above and research by Wood (2015) show early indications that training carers to use music in their daily communication with people with dementia improves the quality of life for both sufferers and their carers.

The more obvious aspect of training and education is the music therapist's specific role in the training of the future workforce of qualified music therapists around the world. On the question of education, to summarise, a music therapist is needed for the following areas:

- To educate others on the specific details of music therapy in practice;
- For music therapy clinical techniques and skills sharing and for training music therapists;
- Qualified music therapy educators are required to train music therapists in universities, in the United Kingdom for example, by law. This insures protection of the public and consistent standards.

Conclusion

In considering the question of when and why a music therapist is needed, a summary of the points discussed above suggests that music therapists have unique roles to offer at all stages of dementia. In early stages working with the impact of dementia on families and carers, and in late stages, literally training carers and families in how communicating musically is effective. The specific unique interventions of music therapists are helpful at all stages for the person with dementia. At all five stages of dementia, musical and music therapy interventions are needed and should be defined as central pathways of care. In some stages music therapists are needed to work more directly with many participants, especially in the later stages when verbal interventions do not work, and the specific skill of the music therapist to work through music is needed. In earlier stages when people with dementia can still access more mainstream musical activities, they may work alongside others who are delivering community choirs, providing advice and sometimes participating.

More work is needed to map exactly when a music therapist is needed, but clearly there is now evidence of trends showing the unique intervention for people with dementia clearly defined in early preventative stages. This can slow down the process of deterioration of communication and expression in these early stages, and also in later stages, especially when language deteriorates and there are behavioural and psychological problems.

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Lecture 3

Improvisational music therapy in neurological rehabilitation

Wolfgang Schmid

University of Bergen, Norway

This lecture paper discusses improvisational music therapy in neurological rehabilitation. The exemplification of actual improvisational processes and ethical considerations in neurological rehabilitation will be the focus of this paper. With reference to music therapy practice in both inpatient and home-based settings, music therapy research, as well as to music sociology and neurobiology, the paper will respond to the two questions: *'Why music?'* and *'Why and when is a music therapist needed?'*.

Music and music therapy in neurological rehabilitation

Music therapy has been increasingly established in neurology and neurological rehabilitation, both in practice and research within the last two decades (for overviews, see Aldridge 2005; Baker & Tamplin 2006; Baumann & Gessner 2004; Bradt et al. 2010; Schmid 2014). The therapeutic application of music focuses on core issues following neurological illness and trauma such as:

- ❑ reduction of drive;
- ❑ disorders of consciousness;
- ❑ disturbances in cognitive and executive functions;
- ❑ coping with loss of functions and social roles;
- ❑ speech and language disorders

In addition, a variety of specific assessment tools and manuals based on music-making or musical elements such as rhythmic or melodic patterns have been developed. Baker and Tamplin

(2006), and Weller and Baker (2011) implemented manuals for persons with altered states of consciousness or cognitive challenges. For the rehabilitation of individuals with aphasia, Baker (2011) introduced an adapted Melodic Intonation Therapy approach, and Jungblut and Aldridge (2004) invented the programme SIPARI, a type of rhythmic-melodic voice training. Recently, Magee and colleagues (2012) have developed the instrument MATLAS for the assessment of low awareness states, and MATADOC (Magee, Siegert, Lenton-Smith & Daveson 2013), a music therapy assessment tool for disorders of consciousness. Improvisational music therapy has been implemented for the assessment and therapy with individuals with multiple sclerosis and traumatic brain injury (Gilbertson & Aldridge 2008; Schmid 2005; 2014).

The individual's perspective in neurological rehabilitation

Individuals in neurological rehabilitation are often confronted with various types of challenge at one point in time. They may experience a complexity of symptoms affecting their communicative, physical, psychological, cognitive, social, and emotional abilities (Schmid 2005). The severity and intensity of the changes following neurological trauma may vary (Daveson 2008; Kolb & Wishaw 2004). In addition the individual's family, children and friends might be affected by the often profound changes, expressing needs for psychosocial support themselves (Gilbertson 2015; Schmid 2015; Schmid & Ek Knutsen 2016). To be able to fully meet an individual's needs in his or her rehabilitation and coping process, a broad range of music-based and music therapeutic approaches, techniques and manuals must be available; these should be applied by qualified music therapists (Jochims 2005).

A case vignette

A 72-year old man with Morbus Parkinson was referred to music therapy by his neurologist on a neurological ward in a general hospital. In the music therapy room, the man decides to play on a steel drum, as he became fascinated by both the shape and the sound of the instrument. After an initial phase of exploration, a lively and vivid improvisation takes shape, jointly co-created by the man and the music therapist. With mutual initiatives, sounding the depth of a broad range of dynamic and expressive qualities in metric and non-metric modes, both drive forward the music. Finally the man determines the end of the joint improvisation by setting the last tone, turning round to the therapist and commenting on the spontaneous joint music-making with the words: "I feel so lightened up!"

Music experience in music therapy

Music-making can provide a bodily experience, causing a perceived change of physical condition in individuals. Improvising actively engages the senses, giving kinaesthetic feedback and sensory stimulation (Bruscia 2014: 142). A sensory, body-based expression of our constitution and way to act and interact with the world becomes audible and can be shared with others (Schmid 2005). As human beings, we own an inborn *communicative musicality* (Malloch & Trevathen 2009), enabling us to distinguish elements of rhythm, pitch and melody, and interact on a bodily and musical level with others. This capacity is the vivid agents of our social and emotional lives throughout our lifespan. In improvisational music therapy, *communicative musicality* constitutes the underlying matrix for shared meaning-making and understanding of the individuals involved (Schmid 2014).

Music as a composed, improvised or performed piece of art can be part of the music therapy process. However, an individual's experiences with the relational processes emerging in joint music-making – intrinsic and extrinsic in their nature – are essential and unique features of music therapy. These *music experience*s can take place on three different levels:

- the intrinsic relationships that are created between the sounds themselves;
- the extrinsic relationships that are created between the sound experience and other human experiences;
- the interpersonal and sociocultural relationships inherent in the process of making or experiencing music (i.e. "musicking") (Bruscia 2014: 118).

Autopoietic processes

Intrinsic and extrinsic music experiences are central to improvisational music therapy. They are the origin of an individual's self-activity, despite disruptions and limitations following neurological trauma. In improvisational music therapy players and singers invent the music by acting and interacting with each other, gaining orientation and creating meaning. These processes can be related to the concept of self-organisation and a systemic-constructivist perspective referring to the *theory of autopoiesis* developed by two Chilean philosophers and neurobiologists, Maturana and Varela (1987). Maturana and Varela intended to develop a theoretical model for the complex processes of living systems, going beyond existing mechanistic, one-way, cause-and-effect-patterns. Self-organisational processes are based on the idea that life constantly invents itself in a dynamic interplay of maintaining and modifying, accepting and releasing (Cormann 2011). Process and product become the same as we experience ourselves and others while forming the ground for these experiences to happen. We hold and experience ownership over the developmental and relational processes we are part of. Improvisational music therapy stimulates autopoietic processes, and individuals enactively implement the therapeutic course instead of being the recipient of a programme. As demonstrated in the case vignette, elements like emergence, autonomy, agency, sense-making, and changes in bodily-emotional perception can occur. Consequently, a professional therapeutic setting with a qualified music therapist provides indispensable conditions for autopoietic processes in individuals affected by neurological illness and trauma (Schmid 2014).

A second case vignette

In a research project on home-based music therapy for individuals living with amyotrophic lateral sclerosis (ALS) and their caring spouses (Schmid & Ek Knutsen 2016), a participating couple gave detailed feedback regarding their experiences of listening to music as part of their weekly music therapy sessions. Listening to music became a meaningful and favourite activity for the couple, as they could spend quality time together and experience a sense of flow. They had differing experiences, however, with regard to listening to self-selected, recorded music versus listening to live music, performed by the music therapist:

- Their preferred music triggered the couples memories and associations. They each selected songs and musical pieces meaningful to them from Spotify or YouTube and played them to each other. In this way, they could present each other their favourite music, and share meaningful histories alongside the chosen pieces.

- In contrast, listening to live music performed by the music therapist and tailored to the couple's situational wishes and needs, was connected to the experience of an exclusive concert taking place in their living room, and the experience of living in the present.

- Improvisations by the therapist on a guitar or a kantele, a small pentatonic string instrument, enhanced the feeling of living in the present and facilitated relaxation in the couple (Schmid & Ek Knutsen 2016).

In summary, listening to music was found to be an *activity*. While different approaches to music listening carried different experiences and meanings for the couple, listening to preferred, self-selected music could be conducted *without* a music therapist being present, and whenever the couple felt like doing so. The findings of this explorative study are relevant with respect to the question *'Why and when is a music therapist needed?'* and need to be further investigated. However, in light of long-term processes in neurological rehabilitation in various settings, and with the possibility to include family members to enjoy preferred music together at home, the music therapy discipline is asked to initiate music experiences owned and conducted by individuals themselves, without a music therapist being present.

Why music matters[6]

The *temporal organisation* of music is a basic structuring component in both music-making and music-listening. The perception of temporal structure and regularity of music is essential for the coordination of movement, and invokes brain regions involved in motor control (LaGasse & Thaut 2012). As an ongoing underlying matrix of music, *temporal organisation* in improvisation provides "a moment-by-moment scaffolding on which people can develop their own embodied musical participation" (Procter 2011: 252). In improvised music, an individual does not need to fit into a given musical structure, or conform to the tempo or metre of a pre-composed song or music-based exercise. In contrast, he or she *co-creates the temporal organisation* of the music emerging, being directly involved in the process of organising time and activity, experiencing a sense of "a continuing present" (Frith 1996: 148f). This experience of creating the music in the framed openness of mutual activity is unique to improvisational music therapy. It is dynamic and relational in its very nature, allowing individuals to attune with each other over time, meaning that they coordinate and synchronise their mutual activities in the simultaneity of music-making over time. The psychologists Lindenberger, Li, Gruber and Müller (2009) found cortical phase synchronisation in guitar players improvising with each other. In their EEG-based study, 'Brains swinging in concert', they concluded that interpersonally coordinated actions are preceded and accompanied by between-brain oscillary couplings.

However, the temporal organisation of music, the co-creation, coordination and synchronisation of activities are integral ingredients of social micro-processes happening in joint music-making (Hesmondhalgh 2013). They *are* features of "music's ability to connect people" (Hesmondhalgh 2013: 117), and in turn facilitate people to connect in music in meaningful ways. They exemplify the "mutual tuning-in in the formation of relationships, allowing for the experience of *We*, and forming the very essence of all meaningful human communication", as the Austrian philosopher and sociologist Alfred Schütz has put it in his essay *'Making music together'* (Schütz 1951: 92).

For individuals in neurological rehabilitation who do not or cannot respond to countable or objective measurements of a standardised music manual, nor join a pre-composed piece of music due to severe, complex and limiting conditions following neurological trauma, possibilities for the experience of *We* become most important. This is a question of ethics, pointing to accessibility of therapy as a requirement for inclusion to happen. Music improvisation invites people to join in – wherever the starting point may be. In mutual co-creation with a trained music therapist, who might first of all be a listener, they are encouraged to tell their narratives, sustaining a sense of identity, and creating feelings of belonging and connectedness.

Closing thoughts

The benefits of music therapy in neurological rehabilitation are currently more and more implemented in interdisciplinary clinical practice, understood, extended and supported by findings from the neurosciences. At the same time, however, we need to identify limitations and potential contra-indications of music and music therapy in neurological rehabilitation.

David Aldridge (2005) described neuro-degenerative diseases as *dialog-degenerative*, pointing to the necessity of averting isolation of people, and critically reflecting on music therapy's role and responsibility in a medical treatment context. In autopoietic processes an individual's intrinsic and extrinsic experiences form both music and relationship. Isolation can be overcome, and embodied dialogue take place, co-created and led by those involved. All these aspects may motivate an individual to take part and, more importantly, stay involved in often long-lasting and demanding rehabilitation processes.

[6] In his book *'Why Music Matters'* (2013), David Hesmondhalgh, Professor for Media, Music and Culture at the University of Leeds, critically investigates and questions music's value for the lives of people and societies.

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Reflection paper

Music therapy for prevention of stress and mild cognitive impairment

Bolette Daniels Beck

Aalborg University, Denmark

This short reflection paper serves as another perspective on the contributions on music therapy and neurodegenerational diseases presented at the Music Therapy Symposium, April 2016, in Aalborg (Odell 2017; Ridder 2017; Schmid 2017). This author participated in the discussion panel as a music therapy researcher in stress- and trauma-related disorders.

The fact that the number of people diagnosed with dementia and other neurodegenerational diseases in our Western societies is increasing, is worrying. In preparation for this symposium I investigated if there is a relationship between the amount of life stress and the onset of dementia or mild cognitive impairment (MCI), a condition of a slight but measureable decline in cognitive abilities, including memory and thinking skills. According to the Alzheimer's Association a person with mild cognitive impairment is at an increased risk of developing Alzheimer's or another form of dementia (http://www.alz.org/dementia/mild-cognitive-impairment-mci.asp).

Several studies point to a relationship between stress and MCI/dementia. Researchers from Albert Einstein College of Medicine in New York followed a group of 70-year old persons from Bronx (n=507). At a three-to-four years follow-up, 71% had developed mild cognitive impairment, and those who experienced high and persistent levels of stress at baseline were twice as likely to develop mild cognitive impairment than those who felt less stressed (Katz et al. 2015). In a prospective longitudinal population study 800 middle-aged Swedish women were followed for 38 years, during which 153 developed dementia at a mean age of 78 years. The researchers found that the number of psychosocial stressors (e.g. divorce, widowhood, work problems and family illness) and long-standing distress were independently associated with the onset of Alzheimer's dementia (Johnassen et al. 2013). Those who had experienced the highest numbers of stressful events in their middle age had 21% higher risk of developing Alzheimer's dementia, and 15% higher risk for other types of dementia.

In order to prevent the onset of dementia and other neurodegenerative disorders in the population, reduction of stress in general is an important focus.

From brain research, we know that chronic stress attacks the brain in several ways. Continuous high doses of the stress hormone cortisol destroy brain cells in whole areas of the prefrontal cortex, causing limited ability of decision-making, planning, reflection and emotional regulation (Ansel et al. 2012; Ghosh, Laxmi & Chattarji 2013). Cortisol also reduces the production of serotonin and dopamine and thereby decreases wellbeing and motivation (Tafet et al. 2001). The plasticity of the brain is reduced because cortisol inhibits the production of new brain cells (Issa et al. 2010). Finally, cortisol increases the connection between hippocampus and amygdala, whereby a higher level of arousal and vigilance is stimulated (Chetty et al. 2014).

What can be done to decrease stress and thereby prevent the onset of dementia? Studies in brain response to music interventions show that the hyperactivated connection between amygdala and hippocampus can be reduced (Koelsch 2009), and that brain areas connected to emotions, pleasure, motivation and reward are stimulated during music listening (Blood & Zatorre 2001). A meta-analysis of 400 studies shows how music interventions can reduce stress, provide social engagement and improve the immune defence (Chanda & Levitin 2013). Several meta-analyses show that music therapy and music medicine interventions decrease stress levels in medical settings, occupational settings and everyday life (Dileo & Bradt 2007; Pelletier 2004). Music listening, and amateur playing and singing, choir singing, recreational music-making, playing in bands, music groups etc. are improving health and decreasing stress (Beck 2013). A recent Danish epidemiologic study shows that there is a connection between health and daily music activities (Bonde, Ekholm & Juel 2015).

When is a music therapist necessary? When a

person suffers from chronic clinical stress conditions it can be very difficult to heal oneself. The autonomous nervous system is highly dysregulated, sleep is disturbed and there can be serious symptoms such as high blood pressure, depression, loss of voice, overwhelming fatigue and cognitive problems. There are many possible treatment options on the market – but what is special about music therapy? As already described, music interferes directly with the stress system in the brain, and is able to calm down the nervous system by creating a safe and holding environment. Music listening can be used together with guided relaxation and imagery. In the receptive music therapy method – Guided Imagery and Music – the patient suffering from stress works with spontaneous inner imagery while listening to music in an altered state of consciousness. The patient tells the therapist about the imagery and they work together to explore emotions, body sensations, memories, visual imagery and thoughts. A randomised controlled study showed that 20 patients suffering from stress on sick leave significantly increased coping skills, reduced anxiety and depression, and decreased cortisol levels with Guided Imagery and Music (Beck, Hansen & Gold 2015). Music therapy interventions with post-traumatic stress (PTSD) populations have shown improvement in sleep quality (Jespersen & Vuust 2012), PTSD symptoms (Carr et al. 2012), trust and social engagement (Bensimon, Amir & Wolf 2013).

Summing up: the task to keep the brain healthy is not only taking place in the head (the brain is enactive, embodied and embedded) it is playing together with the body and its sensory pathways, other human beings and creatures, and the physical world and environment. In order to prevent stress and thereby the onset of MCI and dementia, we as citizens need to be able to participate in mutually engaging, supportive, communicative environments – which can be facilitated by musical meetings and activities. Active engagement with music is important for public health and should be widely supported in schools, institutions, hospitals and local communities. Music therapy is a cheap, non-invasive, easily administered treatment option for people suffering from serious stress symptoms and disorders.

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

Roundtable presenters
Jacobsen, Trondalen, McFerran

Discussion group members
Holck, Loth, Stensæth

Moderator
Dileo

A reflexive introduction

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

Stine Lindahl Jacobsen
Aalborg University, Denmark

Gro Trondalen
Oslo University, Norway

Katrina McFerran
Melbourne University, Australia

Ulla Holck
Aalborg University, Denmark

Helen Loth
Anglia Ruskin University, United Kingdom

Karette Stensæth
Oslo University, Norway

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

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

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

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

Lecture 1

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

Stine Lindahl Jacobsen

Aalborg University, Denmark

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

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

Depending on individual cultures in different

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

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

Why a music therapist?

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

In research on the effect of music therapy a holistic view of man is evident. Looking across client groups biologically, music therapy has a positive effect on pulse and blood pressure, respiration, perception of pain, lung function and agitation (Bradt et al. 2010; Bradt & Dileo 2011; Bradt et al. 2011; Vink, Bruinsma & Scholten 2011). Psychosocially, music therapy has a positive effect on mental state, depression, anxiety, psychosis, initiative and mood (Bradt et al. 2011; Maratos et al. 2009; Mössler et al. 2011). Socially, music therapy has a positive effect on social interaction, non-verbal communication, social-emotional mutuality, social adaption and parent-child relationship (Bradt et al. 2010; Geretsegger et al. 2014). From an existential perspective, music therapy has a positive effect on quality of life, hope and spirituality (Bradt & Dileo 2011; Bradt et al. 2011). The broad perspective of research tells us how music therapy – which we presume includes a music therapist – is relevant as it has quite a range of positive effects for many different individuals and groups with specific challenges in relation to health.

When is a music therapist needed?

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

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

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

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

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

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Lecture 2

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

Gro Trondalen

Norwegian Academy of Music, Norway

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

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

Why music?

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

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

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

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

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

When is a music therapist needed?

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

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

[7] Downloaded from http://www.ohchr.org/EN/UDHR/Documents/UDHR_Translations/eng.pdf

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

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

Why is a music therapist needed?

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

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

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

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

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

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

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Lecture 3

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

Katrina McFerran
University of Melbourne, Australia

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

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

> "Recognizing that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others" (Point E).
>
> "Emphasizing the importance of mainstreaming disability issues as an integral part of relevant strategies of sustainable development" (Point G).
>
> "Recognizing the importance of accessibility to the physical, social, economic and cultural environment, to health and education and to information and communication, in enabling persons with disabilities to fully enjoy all human rights and fundamental freedoms" (Point V).

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

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

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

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

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

and requires action in those arenas.

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

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

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

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

- Creating mutually empowering conditions so that people can flourish (resource-oriented);
- Revealing the complexities of what music can help us understand (insight-oriented);
- Carrying responsibility by providing direction and structure when necessary (supportive);
- Advocating and agitating for changes in the oppressive systems that see people in deficit and fail to celebrate the gifts of diversity (anti-oppressive).

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Reflection paper 1

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

Ulla Holck

Aalborg University, Denmark

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

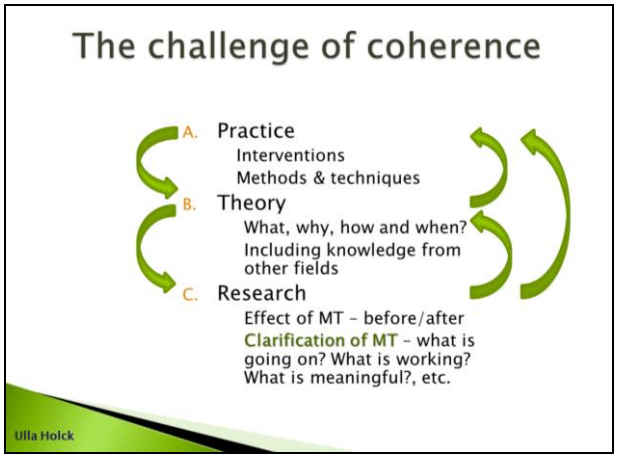

Figure 1: The challenge of getting coherence between the practice, theory and research within music therapy[8]

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

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

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

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

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

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Reflection paper 2

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

Helen Loth

Anglia Ruskin University, United Kingdom

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

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

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

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

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

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Reflection paper 3

Why 'why'?

Karette Stensæth

Norwegian Academy of Music, Norway

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

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

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

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

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

Does my meta-perspective here really respond

[9] See the documentary here: https://tv.nrk.no/program/KMTE30000614/jihad-hellige-krigere

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

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POSTLUDE

Lars Ole Bonde
Aalborg University, Denmark

After the three rounds of presentations on the symposium day, represented here by three article parts, I had the opportunity to make an 'instant summary' of the answers and reflections from all three roundtable presentations to the two overarching questions of the seminar: '*Why music?'* and '*Why and when is a music therapist needed?'.*

My personal 'idiosyncratic summary' contained the following main points:

- There do not seem to be a few simple *common* answers to the questions!
- There are many good and possible answers to the questions within the specific clinical areas – and they are always influenced by who you ask and in what context.

In other words: *The answers are specific to clinical context and culture.*

- We agree that we must work in interdisciplinary teams and that we must train other professional and lay caregivers in using music. We must work also as consultants.
- We agree that we need to be more visible in the public. We need more case videos that really show the 'truth' and clarify the differences between music (alone), music medicine and music therapy.
- We need to stand up for our clients' rights – including outside of the therapy room.

Having read the written versions of the presentations in the form of reflexive introduction papers, lecture papers and other reflection papers, I think these points are still valid. The diversity of the answers, especially to the first question, is not so surprising. Different aspects of what music – and musicking – is, are in focus dependent on the clinical context. The answers can by sorted systematically by using a theoretical model I have presented in the book *'Musik og Menneske'* [Music and the Human Being], based on ideas by Even Ruud (Bonde 2011, 2016; Ruud 1998, 2016a).

The four basic levels of music experience and analysis are: (1) the physiological and biological level of music as a *sound phenomenon,* with corresponding rationales from natural science, such as neuropsychological theory; (2) the level of music as non-referential meaning or syntax, music as a *structural phenomenon,* corresponding to rationales from, for example, musicology or structuralism; (3) the level of music as referential meaning, music as a *semantic phenomenon,* corresponding to rationales from cognitive or analytical psychology, such as cognitive metaphor theory; and finally (4) the level of interpersonal communication, music as a *pragmatic phenomenon,* corresponding to rationales from anthropology or community psychology, such as the theory of communicative musicality.

In the papers included in this special feature, you will find references to all these types of rationales, be it brain research and biomarkers (Odell-Miller), psychosocial theory (Ridder), theories of early infant development (Trondalen), dialogical theory (Stensæth), anthropology, systems and attachment theories (Jacobsen; Schmid), and the social rights of people with disabilities/social theory (McFerran). Again, we see how choice of answer/theory/level is closely connected to the clinical (or non-clinical) context.

The (changing) role of the music therapist is addressed by most of the authors. There seems to be consensus that the traditional work in a protected clinic room can only be part of the contemporary professional profile, given that the profession is reaching out more and more not only to clients or patients with defined diagnoses and needs, but also to the communities they belong to (outside their partial identities as 'patients'). This reflects the transition "from music therapy to music and health" that has taken place over the last ten to 15 years (Ruud 2016b). It has become natural to include relatives and caregivers in the therapeutic activities and processes, and it is no longer perceived as a threat to the profession to share techniques and materials developed by music therapists; on the contrary, it is inevitable that music therapists work in interdisciplinary teams and serve as consultants to families, staff and stakeholders. In this process, many other challenges were identified in the seminar:

- ‘Levels of practice’ need to be defined better – corresponding to contexts, patients’ needs and the music therapist’s role.
- ‘Emotion balance problems’ could be a more appropriate concept than pathologies.
- We need to have good answers to the question of when to use music and not art. Moreover, we should be able to identify situations where music is *not* needed.
- Music therapy is often labelled a ‘non-verbal therapy’? But is this really true, given the proficiency of verbal interventions? Perhaps we should find a more precise term?
- The specific organisation of our healthcare systems presents serious challenges. We need to know more about similarities and differences – in order to support each other in initiatives promoting professional authorisation and clinical recommendations.
- Given that we must develop our role as consultants, we must find precise answers to the questions: *how* shall we train *who, where* and in doing *what*?
- The power of a good case video is evident. Even lay people can easily observe the phenomenon of ’balancing emotion’ in music therapy, which is difficult to describe in words only. Therefore, we urgently need more public videos and other media presentation formats.
- Quality of life (QoL) is becoming an increasingly prominent aspect of effect studies as well as quality assurance, and QoL may be the most promising ‘variable for the future’. But we need to identify the specific contribution of music (therapy) to better QoL.
- Music is a common right, and access to music should be given to patients by caregivers also – not only in dementia. The role of the music therapist as consultant is a given, but we must describe and discriminate between what we and caregivers do in a more precise way.

These questions and dilemmas are addressed in some of the texts, and I think they will be part of the agenda not only for future symposia but for the discussion of the future of our profession. I also think that the next logical question to be addressed is: ‘*Why does music therapy work?’* And why do we still need to ask *‘Why?’*

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Article

A community music therapy project's journey

Bethan Lee Shrubsole

ABSTRACT

Since starting the music therapy Community-Based Organisation (CBO) Music for Peaceful Minds (MPM) in July 2008 there have been on-going gradual but significant changes to the way music therapy is practised and spoken about worldwide that has both challenged and informed MPM's local practice in northern Uganda.

This paper is a personal reflection of MPM's work over the past seven years with an aim of explaining what it means to work as a music therapist with a community-driven frame of mind when working in places that need a flexibility of approach. How has this work moved away from conventional music therapy (where symptoms and health problems at an individual level are focussed on in a therapeutic space) (Stige 2002)? And how has MPM evolved alongside the music therapy profession's changes over the years since the emergence of community music therapy?

KEYWORDS

community music projects; Uganda; community music therapy

Bethan Lee Shrubsole set up the Music for Peaceful Minds (MPM) project in northern Uganda in 2008 and has been supervising its therapists since then. From 2011 until 2015 she worked as a music therapist in western Uganda, working with children with autism, Down's syndrome and hearing impairments in a government school. She now lives in Cambridge with her husband and two sons, working in schools around the county as a music therapist.

Email: musicforpeacefulminds@yahoo.co.uk

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INTRODUCTION

The aim of this paper is to share my experiences of starting the music therapy programme Music for Peaceful Minds (MPM) in northern Uganda whilst working through my own confusion about whether or not what I was doing was 'music therapy'. I also began to question whether or not it mattered if what I was doing was music therapy or a more community-centred music therapy. Some readers may wonder why I am struggling with the idea of community music therapy since discussions about it have been around since at least 2002. Aside from the fact that community music therapy is still an "emerging movement" (Stige 2014: 47), the answer is that none – or at least very little – of my training[1] focussed on community music therapy and in the first few years since graduating I did not come across much practice of community music therapy in my area of special needs work in the UK. During the seven years of running MPM in Uganda I met

[1] I studied a Masters in Music Therapy at Anglia Ruskin University, Cambridge, in 2006.

several practitioners (most of whom were newly qualified music therapists and some of whom were volunteers for the project) who had not heard of community music therapy, despite the amount of literature written on the subject. As the work I was doing in Uganda used to constantly go against a lot of what I considered were the 'rules' of music therapy (keeping confidentiality, having 'strict' boundaries of space and time, for example), I used to worry that the work I was doing in Uganda was not 'real' music therapy. So I decided that I would share MPM's work to encourage music therapists that community music therapy is happening all around us, giving us a new freedom to meet the needs of the communities in which we work.

I begin the paper by outlining some of the discussions about community music therapy so far and notice through my own interactions with music therapy colleagues that community music therapy, although it is not a new concept, is still not a common idea to some music therapists practising today. I then introduce the work of Music for Peaceful Minds (MPM) and explore how it has evolved since it started in 2008 by looking at some of the institutions that MPM works with in turn and describing each one's needs and therefore how MPM has had to negotiate various demands made by the institutions. The final section summarises MPM's journey and brings it in line with how the music therapy profession has evolved, and is still changing.

This paper is intended to inform music therapists about work that is being done in Uganda; I am English, and was working with Ugandans, and I know that working in cultures different to one's own can be confusing and challenging. My hope is that others who are starting similar endeavours can take ideas and encouragement from the struggles that I have been through and hopefully draw courage to work in the way that best fits their area of work. This paper is not claiming to be a research study or theoretical analysis, rather a personal reflection of one community music therapy project's journey.

CONTEXT

Recently I was reading some community music therapy literature and was particularly taken by music therapist Powell's (2004) piece of work in a residential home and day care centre for the elderly because she used the analogy that the residential home's community was married to music therapy and formed a reciprocal relationship. This equal relationship struck me because I had always thought of music therapy as being delivered to the community, not working in partnership with it. For Powell, working in the residential community necessitated flexibility in the way she worked, and she was able to link in aspects of her previous work as a community musician, which she describes as being

> "about inclusion and empowerment; about giving people a voice; about social interaction and often community action through the arts" (Powell 2004: 168).

She wrote that all the different aspects of her work in the residential home (individual, open groups, closed groups, performances and spontaneous groups) meant that her music therapy work had to evolve. It did so

> "in response to the varied and changing needs of individuals and the institutional community, developing beyond the more conventional therapeutic boundaries of time and space" (Powell 2004: 171).

This resonated with me because my work in Uganda has also needed to evolve. As founder of – and music therapist for[2] – Music for Peaceful Minds (MPM), a Community-Based Organisation (CBO) in northern Uganda, I have a similar outlook on how my understanding of conventional music therapy[3] had to evolve according to the context in which MPM works. MPM currently operates as a peripatetic music and art therapy service in Gulu, northern Uganda within a variety of institutions including special needs units and a juvenile detention centre. It exists to provide creativity and counselling for children in Ugandan institutions that otherwise may lack these services. (There is also a need for the counsellors to have an understanding of the primary or secondary trauma that the children may have experienced during the now-ended 25 year-long rebel war.) MPM offers creativity mainly in the form of play through art and music and the counselling happens as the arts counsellors[4] get to know the children and the

[2] I was a music therapist for MPM in 2008 and have since directed and supervised other MPM counsellors' work.

[3] What Ansdell (2002) describes as a 'consensual model' of music therapy, Stige (2002) refers to as 'conventional music therapy', a model that examines "symptoms and health problems at the level of the individual, to focus the interventions at the same level and to work within the boundaries of a therapeutic space".

[4] The practitioners are called 'counsellors' in order for their roles to be better understood locally and to respect the title of 'music

children in turn open up to them. MPM currently runs large open groups, both large and small closed groups and occasional workshops for parents and guardians of children with special needs.

According to Stige (2014), ideas about music therapy and communities have been emerging since the 1990s, but community music therapy really took off with Ansdell's article *Community Music Therapy and the Winds of Change* in 2002. Since the publication of this article there has been a growing desire, borne out of necessity, to redefine music therapy because it has evolved over the years of its professional existence and now shares some common ground with community music. The idea that Ansdell put forward is that community music therapy [CMT] can encompass both disciplines. He invited respondents to outline how their own work converges with, or diverges from, the ideas in his paper so that we can build "a more inclusive map of this [CMT] territory" (Ansdell 2002). Music therapists whose practice had diverged from conventional music therapy practice needed a new theory because it validated the new and often difficult-to-explain work that they were already doing all over the world (Curtis & Mecado 2004). Stige et al. (2010: 279) also advocated that we should "add to our understanding of community music therapy" since it is still a very misunderstood practice.

In the thirteen years since Ansdell's article there has been more literature written about community music therapy (Pavlicevic & Ansdell 2004; Stige et al. 2010) and discussions are becoming more commonplace both online (see, for example, www.SoundSense.org and www.voices.no) and through continuing professional development (CPD) days and conferences. I have found, however, in my personal experience that there is still a lack of understanding amongst my peers as to what community music therapy is and how it fits in with – or needs to break away from – the theory of conventional music therapy. MPM has enjoyed five European-trained volunteers in Gulu over the years, none of whom knew about community music therapy, but most of whom were not daunted by the differences in practice they encountered, accepting that in this different cultural setting music therapy is bound to 'look' different. However, one volunteer, Ana Navarro Wagner, was so overwhelmed by the guilt of her work with MPM not being 'real' music therapy that on her return to Spain she wrote a Master's thesis about how to reframe her experiences in relation to community music therapy in order to help her understand what she had been doing in Gulu (Navarro Wagner 2013). I thank her for her honest reflections that have also spurred me on to reflect theoretically on the work of MPM.

I, too, have experienced professional guilt about whether MPM is doing 'real' music therapy and, when I began as a newly qualified music therapist, I often felt nervous about 'breaking boundaries' of conventional music therapy. However, since boundaries are being blurred and music therapists are already practising community music therapy I feel I can share my work freely, and unashamedly add my views to the profession's understanding of how things are naturally progressing.

The area of community music therapy is by no means a fixed and defined set of practices and neither should it be because there are as many definitions as there are people to define it. Rykov has a useful idea:

> "Rather than striving for one grand theory of music therapy, music therapy theories must enable us to remain open to ambiguity and the multiplicity of meanings inherent in music and life" (Rykov 2005).

One such theory, or 'key feature' as it is called, that MPM has drawn from and is incorporated into the community music therapy discourse is provided by Gold et al. (2005) and Stige et al. (2010). This key feature of community music therapy called "resource-oriented music therapy" refers to resources as

> "tangible or intangible and may refer to both personal strengths and material goods as well as to symbolic artifacts and relational and social processes that may be appropriated by members of a community" (Stige et al. 2010: 283).

Resource-oriented music therapy is oriented "towards the clients' resources, strengths and potentials, rather than primarily on problems and conflicts, and emphasises collaboration and equal relationships" (Gold et al. 2005).

Community music therapy has been emerging gradually for the last twelve years and this has given music therapists worldwide a theoretical foundation upon which to pin flexible and context-driven practice. I am now able to reflect on my work in Uganda through the framework of community music therapy and music therapy literature.

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therapist' which is, according to the UK standards, protected by the Health and Care Professions Council.

MPM'S WORK

I founded MPM as a peripatetic music therapy service in Gulu in 2008. I started work together with Dutch colleague Jantina Bijpost (whom I thank profusely for her valuable contribution), by offering small, closed music therapy groups for children in SOS Children's Villages, an orphanage where many of the children were traumatically orphaned by the war. The work gained recognition in Gulu and over the years that followed, MPM was invited to offer music therapy in a special needs unit of a school where children often present with autism, Down Syndrome or developmental delay; a boarding school for war-affected children, many of whom had Post Traumatic Stress Disorder (PTSD); a school with a unit for deaf children; a mainstream school in an area badly hit by the rebels and a Remand Home for young offenders.

To start with, the work I did with Jantina looked very much like conventional music therapy:

> "Music therapy has mostly, for the last 30 years, been unduly modest in its aim and applications – restricting its area of help to cultivating intimate relationships with individuals medically classified as physically or mentally sick, and offering such help mostly within the privacy of a therapy room. […] [there has been] the concurrent tendency to individualize both problems and solutions" (Stige et al. 2010: 276).

The work that we did in the beginning focussed on creating intimate relationships with the individuals in a group of six, all of whom had been referred to us as having suffered trauma. The children's problems were considered and we, the therapists, tried to achieve desired therapeutic outcomes for the children. Jantina and I attempted to work within a private therapy room within set time boundaries (as much as was possible in Ugandan culture where spaces are open and people do not keep time). We were the leaders and "sole experts" (Stige et al. 2010: 288) of the group and therefore not considered to be the children's friends, since "music therapy is not usually associated with making friends" (Stige et al. 2010: 287). We were able to run music therapy groups this way because we were analytically trained and therefore able to think about such things as our clients' attachment patterns and internal worlds, and make inferences as to how different aspects of the client's internal world are being presented during therapy and use these inferences to help the client (Priestley 1994). We tried to keep some professional distance from the children we worked with and did not perform to the children or have 'sing-songs' because it has been emphasised that

> "[…] music therapy is a form of psychodynamic therapy, not social therapy, and […] patients might therefore be confused by relating to their therapist as a co-performer, and the transference relationship contaminated as a result" (Maratos 2004: 134-135).

However, as time went on it became clear that there were no local musicians who were willing to give their time for free to play music with the children and when Christmas came around the staff asked me to teach the children some Christmas songs, so I agreed. At the time this made me feel very nervous because I was a newly qualified music therapist and felt I had broken music therapy's rigid – even 'sacred' – boundaries. Stige (2014) was faced with a similar situation as a newly qualified music therapist when a music therapy client (Knut) wanted to play in a marching band. He commented that

> "My music therapy education had not prepared me for this issue, however. Obviously, Knut did not know that music therapists tended to practice with a closed door? All the music therapy practices I knew of focused on change at the level of individual and group, not on community participation" (Stige 2014: 49).

Like Stige noticed when working with Knut, I also saw how much fun the children I worked with were having while singing and how each of them looked visibly more relaxed and happy than they had before. It was around this time that I began to see that this broken community in which I lived and worked needed something from me that conventional music therapy, as I understood it, could not offer on its own. It needed a boost of community spirit that built bridges between former soldiers and their victims; it needed an injection of social skills and lessons in how to play with their peers because children had forgotten how to be carefree. The community also just needed to have fun after 25 years of living in fear!

After six months of working in Gulu, before Jantina and I returned to Europe, we trained a local Ugandan teacher, Betty Acen, to use music as a tool for therapy and counselling. We trained her in a way that enabled her to use music to help children to communicate and play, and taught her some very basic points of analytical therapy such as trying to notice certain responses as the children's transference or projection and to consider the children's attachment patterns. She continued to

run the small music groups in the way which we had taught her, based upon the conventional music therapy model, but adapted them to suit her clients' needs and her abilities to deliver. Over the next year her placements began to change. At the special needs school, there was not enough physical space or staff members available to facilitate small-group sessions so these were stopped. However, the school asked Betty to provide whole-class music therapy sessions for over 40 children. Rather than explaining to the teachers that she could not do it because this is not how music therapy works, she instead took a more 'resource-oriented' approach (Gold et al. 2005; Stige et al. 2010). With this approach, each individual in this new large group brought something of themselves to the group collaborations and together they were empowered through musical activities to transcend the limited expectations that their society had for them. If Betty and I had not allowed our understanding of conventional music therapy to draw from the community's needs, then the special needs school would not be receiving any form of music whatsoever since what MPM does there has gone beyond the boundaries of conventional music therapy. As a result, MPM is following Powell's (2010) lead by helping people to make music together and providing new experiences for people which, in turn, enrich their lives and that of the institution.

Whilst spending time with the teachers and students at the special needs unit I came to realise that they were feeling disempowered due to a lack of respect for their work from parents and even colleagues. Having MPM come alongside the teachers and offer them encouragement through the work with the children, we found that other children in the school were beginning to at least notice and at most have some respect for the disabled children. MPM also demonstrated new ideas that could help to inspire their teaching: it is important for a community music therapist to work with the community, addressing their needs and concerns, and not just to assume that a physical or geographical presence within the community is enough. The Ugandans I worked with would have soon dismissed me if I had not tried to assimilate with their culture and ideas; learning local greetings and ways of relating to each other was as important as the musical ideas I brought. Aasgaard (in Ansdell 2002) stated that his role as a music therapist in palliative care institutions was "to improve the institutional quality of life", which is what we should all, as music therapists or community music therapists, aspire to do, since many of the people with whom we work spend their lives in an institution, which may be the only community they experience. This means that we cannot always work "at the end of a corridor, outside the perimeter of the [institution]" (Maratos 2004: 134) because our work needs to be within the hub of the community in order that we may get a feel for what is of best use for that community.

Special unit for deaf children

In January 2012, MPM employed an art counsellor, Vincent Okuja, to work alongside the music counsellor and to add another string to MPM's bow, offering a wider range of creative therapies to the children MPM worked with.[5] Vincent joined Betty at the unit for deaf children at Laroo Primary School where MPM has run closed groups for around six children since 2010. The children have art and music therapy in a semi-closed setting but the staff members are encouraged to join the groups partly for their own interest and understanding and partly to help Betty and Vince translate sign language. The children also took part in a presentation at a workshop to the parents about music and art therapy where they performed some songs and role-plays for the parents. The aim of this was to help the parents understand what music and art therapy is about and also to learn new ideas about how to communicate with their children.

The idea of performance is another 'key feature' of community music therapy (Stige et al. 2010) but does not mean that performances have to happen in the Western sense of having an audience and a traditional concert environment; rather, by making music, members are performing to each other and therefore revealing themselves to one another. Wood (2006) sets out a model of community music therapy processes that he calls "The Matrix", which includes performance projects and workshops[6]. His view is that people are interconnected therefore

[5] I had read about a case in the Netherlands with Mohammed, a man who had participated in sociotherapy, psychomotor therapy, music therapy and art therapy concurrently (Zwart and Nieuwenhuis 1998). Each of his therapists liaised with each other in order to offer the best help to Mohammed and I was interested to see how art and music could similarly work together for the benefit of the children in Gulu.

[6] Also included in Wood's matrix theory are the processes of individual music therapy, group music therapy, ensembles, concert trips, tuition and music for special occasions although he recognises that each different music therapist may have his or her own variation of processes.

music therapy should also be interconnected.

> "A music therapist can identify the most appropriate formats of music therapy for their client, and be confident that their musical work is part of an interconnected matrix of musical possibilities that has its own safety and rigour" (Wood 2006).

I came to realise that using performance and workshops in MPM's work with the children in the deaf unit, together with their parents and guardians, was a valid and extremely useful way of using music therapy in a community context. In Elefant's (2010) description of her work with children with special needs, she explains that as the children were making music, the staff members were also in the room listening. This brought a sense of performing even though the children were simply making music in the moment. She describes how the children would "glance back at them [the staff members] as if saying 'did you hear me play? Aren't you proud of me?'" (Elefant 2010: 65).

During my time of working in Ugandan schools I have noticed that although the government is trying to implement education for children with special needs[7], there is generally very little value put on these children by teachers and even their own parents. In one case, a deaf girl at the unit for deaf children had been abandoned by her parents and was being brought up by a kindly neighbour. Although there are some teachers who truly take an interest in the children and show genuine care and concern, I also see far too often the children being ignored by the underpaid teachers and they are left to wander around outside the classroom and not encouraged to join in with learning. However, the deaf children in the unit were proud to perform to their carers and show them what they are capable of. They were also happy to have the staff members in sessions with them so that they could be truly seen – their true selves being revealed as they play music or create art.

This openness of the content of therapy sessions through performance is uncharacteristic of conventional music therapy, but it does not mean that it never happens. Ansdell (2005) cites one music therapy client, 'David', with whom he performed at the end of David's therapy. Ansdell saw this performance as "the successful outcome of the individual music therapy process" but whilst reflecting about the therapy with David twelve years later David told Ansdell that this performance had been a highlight of his therapy and Ansdell realised that David considered central something that he himself had thought marginal.

The work happening in the deaf unit of the school in Gulu is also cultivating "the interplay of bonding and bridging" (Stige et al. 2010: 286). The bonding part of the process is to develop relationship ties within the group itself; the bridging part involves reaching out to another community in order to create a 'bridge' for the purpose of uniting the groups. In this situation the deaf children came together as a community and reached out to the parents and others in the wider community outside of the school. Pavlicevic states that this 'bridging' aspect "enables the children to address their elders in a way that would be unthinkable in daily life" (Stige et al. 2010: 286) so when the children in the deaf unit sang songs to their elders, they were able to sing messages such as how you should not give up on children because they are deaf, which is a message they may not have been able to either put into words or even deliver to their elders outside of signed-singing or art.

Remand Home

The work at the Remand Home has not strayed too far from conventional music therapy in that there is confidentiality within the group, some boundaries of time and space and an emphasis on analytical therapy. Ideas for session themes come from the young people, as well as from the therapists, as generated in group discussions during the therapy sessions. As with conventional music therapy, sessions begin and end at set times and usually take place within a set physical boundary and the therapist is not 'on call' to help with things that happen outside of those time or space boundaries.

However, the Ugandan culture offers a different perspective on boundaries (Byakutaaga 2006), and does not have the same ideas about there being a difference between personal and professional boundaries. For example, people often live in tightly-knit communities where they know each other more intimately and there are usually more tangled webs of relationship where cousins, aunts, uncles, brothers and so on live in a closer proximity both physically and emotionally. Added to this is the difficulty of travel in northern Uganda meaning that people often live within walking or cycling distances of their work and therefore can be living in close proximity to their clients, who then see them going

[7] See Ugandan Ministry of Education and Sports, Special Needs and Inclusive Education Department: www.education.go.ug/data/smenu/15/Special%20Needs%20and%20Inclusive%20Education%20.html

about their day-to-day lives. Some traditional models suggest a therapist's professional boundaries may be broken down if she sees a client walking down the road and he wants to stop for a chat, or the client sees where the therapist shops, who they live with and where they spend their social time.

There was one occasion in the Remand Home where these lapsed boundaries served the MPM counsellor, Betty, well so that she could help one of the boys in the Home. A young boy was having difficulty rebuilding his relationship with his father, with whom he had fallen out after the father reported him to the police for illegal behaviour and had him sent to the Remand Home. The boy had been in the MPM music therapy sessions for some weeks during which time Betty began to learn about his situation. She offered to help him by going to meet the boy's father to see if she could help to reunite the father and his son. Over some weeks Betty helped the boy to reconnect with his father even though it was outside of the boundaries of the music therapy sessions.

This crossing of boundaries does not usually happen in conventional music therapy, with the exception that music therapists may work within a wider multi-disciplinary team who may help to follow up certain situations. With the proviso that the music therapist is following the professional conduct required by her post, such as child protection protocols or working within a multi-disciplinary team, it is my view that community music therapists should be allowed to work beyond the boundaries of physical time and space that conventional music therapy (as well as institutions themselves) has put up. In community music therapy there is usually some sort of 'outreach' involved and "there is something more at stake, then than just adding a little unity and fellowship to a standard conception of individual of group music therapy" (Stige et al. 2010: 285).

DISCUSSION

In its early professional years, conventional music therapy needed to have "clear and rigid boundaries based on theoretical principles" as an "attempt by the music therapists to be taken seriously and accorded some status and position within the system" (Maratos 2004: 135). The professional guidelines made sure that music therapy was not misunderstood or misused (for example, some people may believe that music therapy is a medical intervention). However, once music therapy in the UK had received this acceptance and registered courses and regulations were approved by the Health and Care Professions Council, it felt to some as though it had become a closed and inflexible profession (Quin 2014). Now that conventional music therapy (at least in the UK) is secure in its professional status music therapists have started breaking through – or at least repositioning – the walls that protect it professionally from change and opening up the profession to any type of music-making that enables music therapists to "work to accomplish personal change [and be] […] challenged to accomplish social change" (Curtis & Mecardo 2004).

In the early years of starting MPM, I sought advice from UK-based charity Music as Therapy International (MasT), which works in several countries around the world and introduces their local partners to basic music therapy techniques drawn from the UK-model of conventional music therapy through skill-sharing (demonstration in practice). MasT freely accepts, (and even encourages) local ownership of these new skills meaning that each place can adapt the way they practise according to the needs of the country, the culture or the institution in which they are working. MasT 'allows' the local partners to continue to use the term 'music therapy' believing that it can be adapted to suit peoples' needs whilst still essentially being music therapy. I am grateful to MasT for standing with me in my own exploration of how music therapy could be adapted in northern Uganda. I am also pleased that they still use the term 'music therapy' and have not felt the need to modify it or apologise for it because MasT simply accepts that music therapy can be a flexible medium that does not have to stick within rigid professional boundaries. The British Association of Music Therapy (BAMT) had its first conference in February 2014 and took delight in the coming together of music therapists and researchers from many different backgrounds to "share practice, research and celebrate the transformative power music therapy has to play in enriching lives" (BAMT 2014). The BAMT Chair Donald Wetherick introduced the conference in this way:

> "Music therapy is simply too diverse a field to define simply and its richness comes from this overlap between music and the many different fields in which music therapists work. What unites us is precisely our concern with this overlap between 'music' and 'therapy', and all the various subtleties those two words contain" (Wetherick 2014: 15).

This leads us to understand that the term 'music

therapy' can legitimately contain a range of ways of working that might not have been imagined when Ansdell wrote his *Winds of Change* article in 2002. Ansdell (2014) recently wrote a paper commenting on his 2002 article that gives a useful summary of community music therapy's journey so far:

> "CoMT has functioned as a 'trojan paradigm': smuggling into an increasingly reductionist, individualized and medicalized culture of treatment and care a more flexible ecological understanding of the complex relationships between music, people, health, illness and well-being" (Ansdell 2014: 11).

MPM joined this same journey in 2008, from attempting to practise conventional, individualised music therapy in a culture where it is not always appropriate, through a few years of guilt, confusion and blurred boundaries, until it reached the point it is at today of being firmly rooted in relationship with communities, in the freedom that community music therapy offers.

But community music therapy is not at its conclusion yet. As Stige (2014: 52) writes:

> "What I have tried to contribute seems to have formed one little creek that eventually ran into the big river that today constitutes CoMT internationally. Where will the river flow from where we are today? We do not know the landscape of tomorrow, so it is of course hard to predict".

Where will MPM be and what will it be doing tomorrow? I cannot know exactly, but I do know that it will be freely serving its community using music (and creative arts in general) in the best way it can.

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Article

Interactive therapeutic music skill-sharing in the West Bank: An evaluation report of project Beit Sahour

Elizabeth Coombes & Michal Tombs-Katz

ABSTRACT

Interactive therapeutic music skill-sharing projects are becoming more widespread, yet there exists little research into the areas of trainees' motivations and transfer of skills, aspects that seem vital if the projects are to achieve their goals of upskilling employees and benefitting clients. Project Beit Sahour (2012 – ongoing) aimed to equip teachers and social workers with skills to run such groups in their workplaces. This paper provides an evaluation of the project that took place in the West Bank in two mainstream schools, with particular emphasis on trainee motivation, training programme quality and subsequent use and embedding of knowledge and skills. In order to evaluate the training programme, a series of questionnaires were devised and administered at specific times during and after training. Reports were also requested from the schools involved to obtain further information regarding the areas of evaluation. The paper offers an overall summary of findings, and makes recommendations regarding future areas of investigation in projects of this nature.

KEYWORDS

music; therapeutic; skill-sharing; schools; motivation to learn; instrumentality; transfer; skills

Elizabeth Coombes, BMus, MA. Elizabeth is a Registered Music Therapist (HCPC), university lecturer and musician. She is also the Course Leader of the MA Music Therapy at the University of South Wales, Newport. Since qualifying in 2000, Elizabeth has specialised in working with children and young people with emotional and behavioural difficulties. She uses psychodynamic thinking to underpin her work, and also utilises her considerable experience in community music-making. She has worked on interactive therapeutic music projects in the West Bank since 2009, having an interest in how sharing these skills with non-musicians such as teachers and social workers can enrich their professional practice.

Email: elizabeth.coombes@southwales.ac.uk

Michal Tombs-Katz, PhD, Psychology, Cardiff University. Michal is a Chartered Psychologist (AFBPsS) and a Registered Occupational Psychologist (HCPC). As an expert in the field of training and development, Michal uses psychological principles to study phenomena associated with training. Michal presented her work on motivation to learn nationally and internationally and in peer reviewed journals. Most recently, Michal wrote a book chapter for the British Psychological Society titled "*Fostering a Continuous Learning Culture in the NHS: The Role of Leadership*". Michal has extensive experience of teaching in higher education and is the Course Leader of the undergraduate Psychology programmes at the University of South Wales, Newport.

Email: michal.tombs@southwales.ac.uk

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INTRODUCTION

The training of musicians and non-musicians in interactive therapeutic music-making by music therapists is now becoming an established practice in parts of the world where access to music therapy is non-existent or severely limited (Margetts, Wallace & Young 2013). This evaluation project concerns such a project designed and delivered by Music as Therapy International (MasTInt) in the West Bank. For the purposes of this evaluation report, it should be stated that the term *interactive therapeutic music-making* describes a music programme where the music group leader engages in joint music-making with their clients. Activities are selected and devised for their potential to reach therapeutic goals selected by the project recipients in tandem with the project organisers and trainers.

MasTInt is a UK-registered charity whose primary activity consists of providing therapeutic music skill-sharing training led by music therapists in such areas. It was set up in 1995 when the first such skill-sharing project took place in Romania. Since 2009, a broader international remit was added to the charity's mission, with projects being initiated in the West Bank, Georgia and Rwanda. In addition to their international portfolio, the charity runs an interactive music-making course in the UK each year. This seeks to train early years' practitioners in using music to support children's learning and development. Many of their international projects take place in areas of ongoing or past conflict. Staff teams in settings such as care homes and schools are equipped with skills and materials to run interactive music programmes addressing the psychological, educational and emotional needs of children. The charity has developed its own six-week training model which allows for a two-person team of a music therapist and assistant (musician or music therapist) to work with local partners and develop a sustainable interactive therapeutic music programme. Importantly, although the charity has worked in a variety of different countries and settings, each programme is bespoke. Detailed discussion of the aims and objectives of local partners before the training begins, as well as a week of observation on-site equip the training team with information regarding which therapeutic activities may be of use, and which therapeutic approach will be fit for purpose. A training programme is then devised on-site, with a resource booklet being prepared for the trainees after the initial six-week stage of the project is over. Staff are then supported by email, online meetings and newsletters once the six-week project has ended. Reports are requested on a six-monthly basis, with the potential for follow-up visits by the original team, other trainers or more local professionals to further develop staff skills.

In the past 15 years, an increasing amount of evidence, mainly focussing on case studies, describes the value of using music therapy in war-torn or conflicted areas. Sutton (2002), amongst others, has edited a book where an interesting overview of work in areas such as Northern Ireland, South Africa, and Bosnia-Herzegovina is provided. Pavlicevic (2002), for example, writes about her work as a music therapist in South Africa. She describes the complexity of living in a society where it is not necessarily the sudden, frightening outburst of a single violent act, but rather the constant rumbling backdrop of conflict to everyday life that is just as traumatic and unsettling. In this context, she writes movingly of a traumatised child being able to summon a sense of self and revivify their inner *Music Child* through music therapy sessions. In the same edition (Sutton 2002), Lang and McInerney (2002) have also written of music therapy work with the organisation War Child in Bosnia-Herzegovina. They report the importance of creating a safe, containing therapeutic environment to facilitate positive outcomes from music therapy sessions. They see the music-making process as vital to clients being able to safely explore and re-experience difficult feelings resulting from traumatic events in their lives. The non-verbal properties of music-making seemed particularly important, as sometimes clients "simply did not have the words to say what was clearly expressed through the non-verbal medium of music" (Lang & McInerney 2002: 172). Equally, Nicholson, (2014), a music therapist working with traumatised clients in Rwanda for *Musicians Without Borders*, sees the value of the individual music therapy sessions he offers. He believes music therapy provides the opportunity to connect non-verbally in the moment, sharing emotional experiences with another creatively and authentically. Another music therapist, Shrubsole (2010) has described her clinical work in post-conflict Uganda, focussing on the importance of shared aspects of culture as well as the impact of a language barrier. She also references the importance for clients of sharing aspects of their emotional experiences non-verbally in a safe therapeutic space.

Although therapists' approaches may differ, the body of work referenced above describes the ability of music therapy to provide a facilitating environment in which traumatic experiences can be safely explored, and damaging patterns of

behaviour addressed. This has led music therapists to infer that these populations can benefit from music therapy.

It is the case, however, that in some of these and other geographical areas, access to music therapy as a form of intervention is severely limited. This lack has given rise to individuals and organisations such as MasTInt offering interactive therapeutic music-making training projects to local staff in response to a perceived need by training recipients. Although some projects offer qualitative evaluative insights on the efficacy of such training programmes, what is still lacking is a systematic evaluation on the extent to which training is transferred and sustained in the long-term (Coombes 2011). In addition, there is a distinct lack of research into the motivations and expectations of trainees themselves and on the extent to which they believe the training programme is relevant and useful for them. Exploring trainees' motivations and expectations has the potential to support sustainability of training (Coombes 2011), particularly as they were found to be consistent predictors of training effectiveness and transfer (Colquitt, LePine & Noe 2000).

Conceptualised as "a specific desire of the trainee to learn the content of the training program" (Noe 1986: 743), motivation to learn has been found to be central to the success of training (Colquitt et al. 2000). Research to date has shown that motivation to learn matters before, during and after training and it should be promoted throughout the learning process (Salas, Tannenbaum, Kraiger & Smith-Jentsch 2012). Within the literature on motivation to learn the construct is conceptualised as either the amount of effort trainees are prepared to put into learning the training materials (Noe 1986), or as a function of Vroom's (1964) expectancy model (Baldwin & Karl 1987; Mathieu, Tannenbaum & Salas 1992). Whilst one approach considers motivation as a way of gauging how trainees view their participation, the other approach highlights the importance of expectancy of outcomes. Within this framework, instrumentality is particularly powerful in predicting training outcomes, as trainees make instrumentality-based calculations when analysing exchanges with the organisation and when thinking about the anticipated consequences of participating in training (Tharenau 2001). More specifically, instrumentality is concerned with job or career related benefits, and pivotal to the decision-making process is the question of what purpose the training will serve and whether this purpose is likely to be met (Chiaburu & Lindsay 2008). This paper seeks to explore aspects of such a training programme, MasTInt's Project Beit Sahour, that was delivered in two schools in the West Bank. It uses data gleaned from questionnaires and reports to examine trainees' motivations to attend the programme and their expectations of the course, as well as the efficacy of the programme itself. The main questions the evaluation was set to address were as follows:

- To what extent are trainees motivated to attend the training programme?
- To what extent do trainees perceive the training programme to be instrumental and beneficial to their work or career?
- How satisfied were trainees with the training programme?

In addition to these questions, an overarching objective of this evaluation was to gauge transfer of skills post-training. With this in mind, data concerning embedding and confidence of using the newly acquired skills and perceived benefits to work practice were gathered and reported in this paper.

It should be mentioned here that we acknowledge the influence of factors such as 'outsider' professionals working in an unfamiliar culture and other aspects of this work in which cultural difference plays a large part. This evaluation has not investigated these areas in any detail, choosing instead to focus on data gathered from the questionnaires and reports. It should be noted, however, that MasTInt projects do take these issues seriously, and endeavour to consider such matters with great care and sensitivity.

BACKGROUND

Project Beit Sahour is located in the West Bank in a small town close to Bethlehem. Due to the prevailing political situation there is a continual threat of military and civilian violence. Regular incursions by the Israeli military and situations that constantly challenge economic, social and educational stability mean the area is in a state of high tension. Teachers and social workers working in this environment face daily challenges associated with stress and anxiety. The schools involved in this project report high levels of students exhibiting acting out behaviour in classrooms and at home.

Some evidence suggests that Palestinian children regard positive school-based experiences and educational achievement as providing the

potential to offer emotional resilience associated with their living conditions (Qouta 2004). Evidence such as this and reports from Project Bethlehem (Coombes 2011) led the schools involved in Project Beit Sahour to contact MasTInt to explore the possibility of such a training project being offered to their staff.

This training programme was a joint initiative between MasTInt and the Evangelical Lutheran Church in the Holy Land (ELCJHL), a German-based Christian organisation which runs three co-educational schools in the West Bank, and one in Jordan.

THE TRAINING CONTEXT

In September 2012 a team of two music therapists travelled to Beit Sahour, a small town in the West Bank adjacent to Bethlehem to deliver the above training programme to staff at two different schools. For the purposes of this paper and to ensure anonymity is respected, they will be referred to as Schools 1 and 2.

School 1 is based in the heart of the old part of Beit Sahour, a town of some 13,000 inhabitants located to the east of Bethlehem. Situated amongst the winding streets, the school is very much a part of the local community. Indeed, it was first established there in 1901. It is co-educational, and typically had a population of approximately 520 pupils at the time of the training, ranging from 4 to 18 years of age. Many of the students' parents also attended this school, and a significant number of the teaching and support staff are also former pupils. It has 30 educators on its staff list. Pupils are 80% of the Christian faith with the remaining 20% being Muslim.

In comparison, School 2 is situated on the outskirts of Bethlehem and Beit Jala, a neighbouring (almost contiguous) town, high up on a hillside. It is a new school, having been established in 2000. It is also co-educational, and had a typical population of 310 pupils at the time of the project with 31 educators in its staff team. The pupil base for this school is drawn from a less homogenous community than that of School 1 with a more evenly balanced mixture of Christian and Muslim families. Some pupils live in the neighbouring refugee camps while others are located in private homes in Beit Jala or Bethlehem.

A total of 10 trainees, 5 from each school, took part in the training programme; 8 being teachers and 2 social workers. The majority of participants volunteered to take part with 3 being chosen to attend by their managers. All trainees but one were females. The teachers worked in different areas within the curriculum. The average age of trainees was 35, with the youngest being 24 and the oldest being 47.

DELIVERY OF THE TRAINING PROGRAMME

Table 1 displays the timeframe of the training programme and of data collection. The first week (Week 1) was a settling-in period for trainers and trainees. This helped trainers identify needs and devise the bespoke training programme. Trainers spent time observing classes and meeting staff. They also ran one experiential music group for staff. In subsequent weeks (Weeks 2-5) the project team ran daily interactive therapeutic music groups of pupils, with each group receiving a weekly session. One trainee would sit in on a designated group, assuming more responsibility for leading the group week by week. Trainees worked with or observed the same groups during this time. Weekly staff group training sessions were also arranged where principles of music therapy were introduced. The final week (Week 6) was a time when trainers prepared the booklet that was left for trainees to use post-training.[1]

EVALUATION METHOD

Evaluative data were gathered by the use of questionnaires and evaluation reports. Three questionnaires were administered in total to each participant and evaluation reports were requested at two different time points post-training. The timeframe in which these were administered is displayed in Table 1. As can be seen, the first questionnaire was administered at the end of the first week of the project. It included measures of demographics (age, gender) and background variables related to the job. It was designed to tap into trainees' perceptions of instrumentality of the training programme and motivation to learn the new material (see Appendix for measures). Each trainee was allocated a unique number that was entered on

[1] To obtain a copy of the booklet which provides an overview of the therapeutic principles applied and activities used, please contact Elizabeth Coombes.

Timeframe of training	Brief Description of Training / Monitoring Process	Data collection
Week 1	Observation of setting, initial musical experiential group, meeting trainees, devising timetable.	Questionnaire 1 administered at end of the week.
Week 2-5	Interactive therapeutic music groups led by trainers with trainees participating. Training workshops held.	No data collection.
Week 6	Trainees lead interactive therapeutic music groups. Final workshops held. Booklet of activities prepared and distributed.	Questionnaire 2 administered at the end of the week.
5 months post-training	No training activity.	Evaluation reports requested from schools.
6 months post-training	No training activity.	Questionnaire 3 administered.
13 months post-training	No training activity.	Evaluation reports requested from schools.

Table 1: Structure of the training programme and data collection

the questionnaire to ensure anonymity of the data and this number was used in subsequent questionnaires. All items asked participants to indicate on a scale from 1 to 5 how much they disagreed or agreed with statements. All questionnaires were collected by the project team or leader.

The second questionnaire was administered at the end of the 6-week training programme. It re-examined instrumentality and motivation and also included measures of satisfaction with training. This was assessed through rating five statements related to satisfaction with the trainer (e.g. *"the trainer gave me specific guidance as to how I could improve"*), and four statements designed to tap into satisfaction with the training materials and methods (e.g. "Taking part in the pupils' music sessions was the most useful part of training").

The third questionnaire was administered six months after the training ended. It focused on the extent to which trainees transferred the newly acquired skills to the job, the usefulness of the booklet provided and whether they felt that the training was useful for managing behaviour and emotions of children in the classroom. Space for qualitative comments was provided throughout the questionnaire to enable trainees to put additional information with regards to their satisfaction of training.

Reports were requested five months and thirteen months post-training, to ascertain whether trainees were running interactive therapeutic music groups, and if so, to explain their aims in using them, and how often they had managed to run them. They were also asked to report a brief case study on a group or an individual and to note any challenges they had experienced. This aspect of Project Beit Sahour is common to all MasTInt projects.

RESULTS

To recap, the purpose of this paper is to report the findings in relation to the motivations and expectations of trainees, as well as their satisfaction with the six-week training programme. In addition, it seeks to report the findings on the extent to which the newly acquired skills were transferred and embedded in everyday practice. Analyses of the evaluation data were therefore conducted in the following way.

ASSESSING MOTIVATION AND SATISFACTION WITH TRAINING

To assess trainees' levels of motivation and perceptions of instrumentality at the start and at the end of the six-week training course, and to ascertain their satisfaction with the programme, the mean scores were calculated for each scale in questionnaire 1 and questionnaire 2 (i.e., Week 1 and Week 6 of the training programme, see Table 1 above). To accomplish this, scores of the four instrumentality items, the three motivation to learn items, the five satisfaction with trainer items, and the four satisfaction with training materials items were added to form an overall score for each participant. Participants' scores were then added in order to calculate a mean score for the group and this score was then compared to the lowest and highest possible score that could be obtained for each scale.

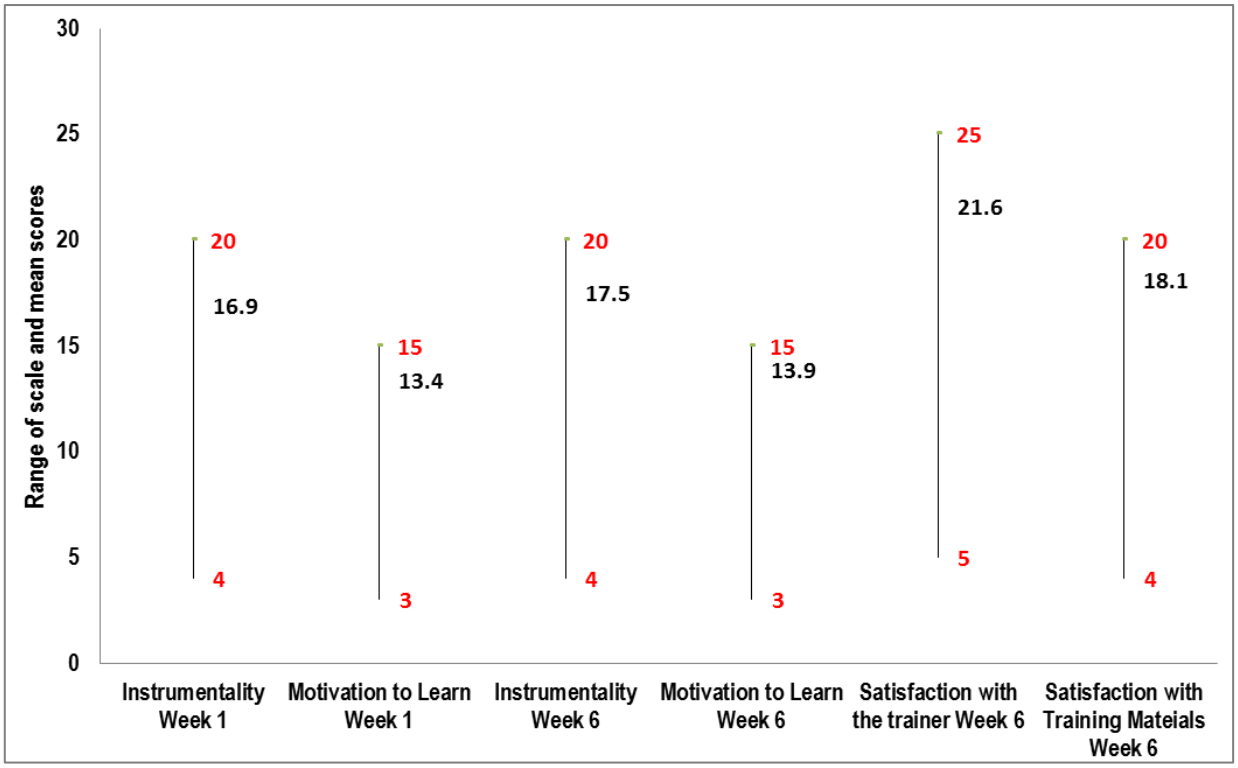

Figure 1: Range and mean scores for instrumentality, motivation to learn, and satisfaction with training

Figure 1 displays the highest possible score and the lowest possible score one could obtain on the instrumentality, motivation to learn, and satisfaction with training scales. It also shows the mean scores for the group. Given that the lowest possible score is 4 and the highest possible score for instrumentality is 20, results suggest that as a group, trainees scored above average on instrumentality at the start of training (Mean = 16.90 at week 1) and also at the end of the training programme (Mean = 17.50 at week 6). Similarly, with the lowest possible score being 3 and the highest possible score for motivation to learn being 15, Figure 1 shows that, as a group, trainees scored above average on motivation to learn at the start and at the end of the training programme (Mean = 13.40, 13.90, week 1 and week 6 respectively). This suggests that, on average, trainees were excited about attending the training course and were prepared to put effort into it, at the start and also at the end of the six-week training period. They also perceived the training to be relevant for their job and that it was likely to provide them with useful skills.

Figure 1 also shows that trainees were highly satisfied with the training course (as measured in week 6). With the lowest possible score of 5 and highest possible score of 25, as a group, trainees scored above average for satisfaction with the trainer (Mean = 21.60). Trainees were also highly satisfied with the training materials. With the lowest possible score of 4 and highest possible score of 20, a mean score of 18.10 suggests that they were satisfied with materials used such as the booklet, and the pupils' music sessions.

Qualitative comments provided by trainees at the start and the end of the six-week training course (questionnaires 1 and 2) reveal that staff from both schools felt they might find the training useful. However, there were some interesting differences between the schools in terms of expectations. Staff from School 1 had pupil-oriented goals such as assisting pupils in lessons and with concentration, while those from School 2 were more self-oriented, hoping to gain new skills. For example, one person hoped to learn how to release their own stress, which was not a primary goal of the programme. The second questionnaire revealed additional differences between the schools. School 1 staff were highly complementary about the trainers, and commented that they could use their newly acquired skills with shy or hyperactive students. In contrast, School 2 staff comments focussed largely on the lack of time trainees had to undertake the training programme and to continue to use it. One person did not feel they would be able to continue to use these skills, while another felt that a teacher wholly dedicated to this work was required. This suggests that although the quantitative data indicate satisfaction with

training, trainees from School 2 may have been more reluctant about the training and the extent to which they can apply it.

ASSESSING TRANSFER OF SKILLS AND SUSTAINABILITY

One of the main objectives of the evaluation was to ascertain the extent to which the training was embedded and used in everyday practice and this was assessed by analysing the answers to questionnaire 3 (six months post-training) and by examining qualitative comments not only in this questionnaire, but also in the two evaluation reports (five months and thirteen months post-training). One of the trainees did not return the third questionnaire and data were therefore available for 9 of the 10 trainees. Figures 2 to 4 offer a summary of the answers provided in questionnaire 3 by trainees.

Figure 2 displays trainees' responses to questions related to confidence and usability of the newly acquired skills six months post-training. As can be seen, all but one trainee felt confident to use the skills and found the booklet to be useful. With regards to usage of interactive therapeutic music groups, five of the trainees either agreed or strongly agreed that they use the skills on a weekly basis.

In Figure 3, trainees' answers to questions relating to how helpful the training was for them in the management of children's emotions in groups and in the classroom are reported. As can be seen, all but one trainee either agreed or strongly agreed that as a result of the training course they felt better able to respond to children's emotions. They were less certain of the extent to which children participating in interactive therapeutic music groups are better at managing their emotions.

In Figure 4, trainees' answers to questions relating to how helpful the training was for them in the management of children's behaviour in groups and in the classroom are reported. As can be seen, all but one trainee either agreed or strongly agreed that as a result of the training course they felt better able to respond to children's behaviour. Again, they were less certain of the extent to which children participating in interactive therapeutic music groups are better able to manage their behaviour.

The qualitative comments noted by trainees in questionnaire 3 (see Table 2) and in the evaluation reports provide examples as to practical activities and how the skills acquired during the training programme were used in everyday practice. Interestingly, staff from School 1 offered almost twice the number of comments as those elicited from School 2. There were many positive comments from School 1 trainees, including those relating to feeling upskilled, feeling able to transfer skills from small groups into whole classes and seeing a difference in pupils' confidence. One person reported being able to use elements of the training at home with their own children. School 2 trainees, in contrast, mainly provided comments on their satisfaction with training, but less about the extent they used it in their work. As can be seen in Table 2, they mentioned issues such as a suitable room being needed, the programme needing a structure and a dedicated timetable, and only one comment was made about usability, stating that they could use some activities in whole classes.

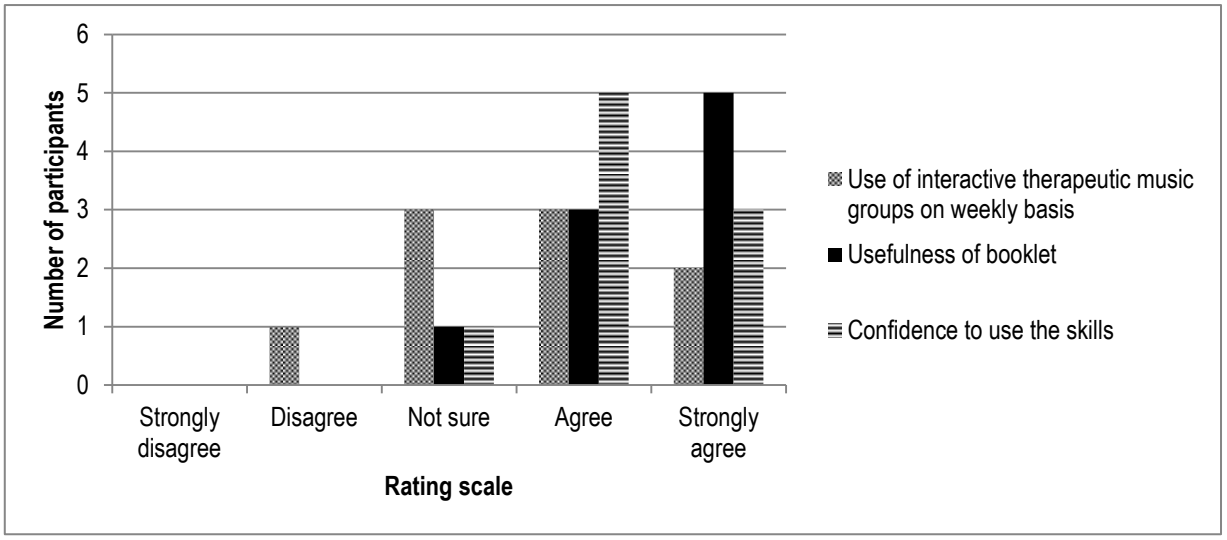

Figure 2: Participants' reporting of confidence to use the new skills, usage of skills, and usefulness of booklet post-training

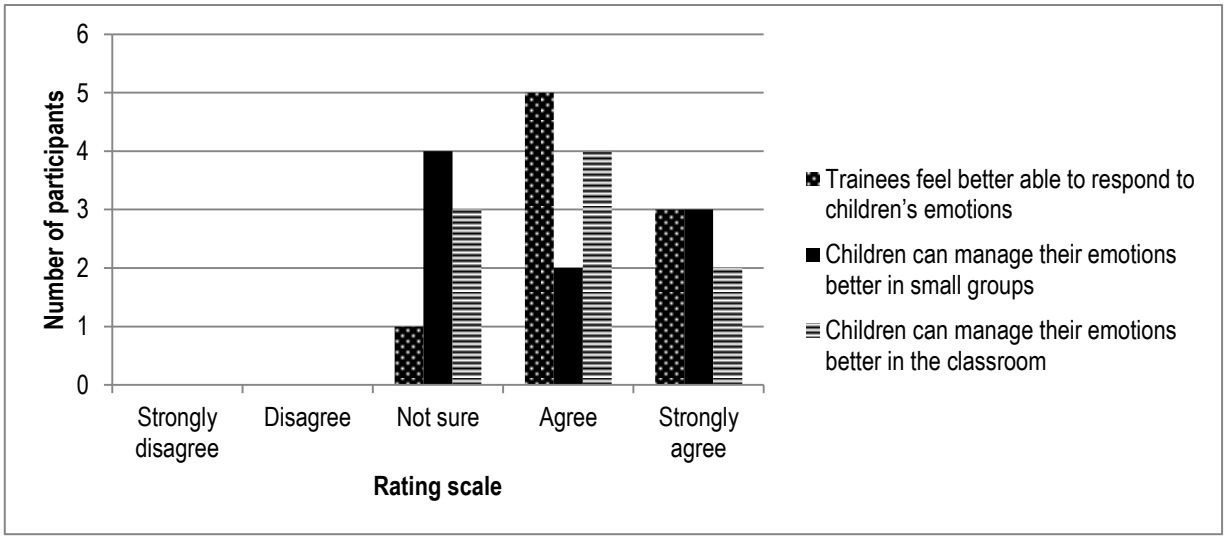

Figure 3: Participants' reporting of how helpful the training was for them in management of childrens' emotions

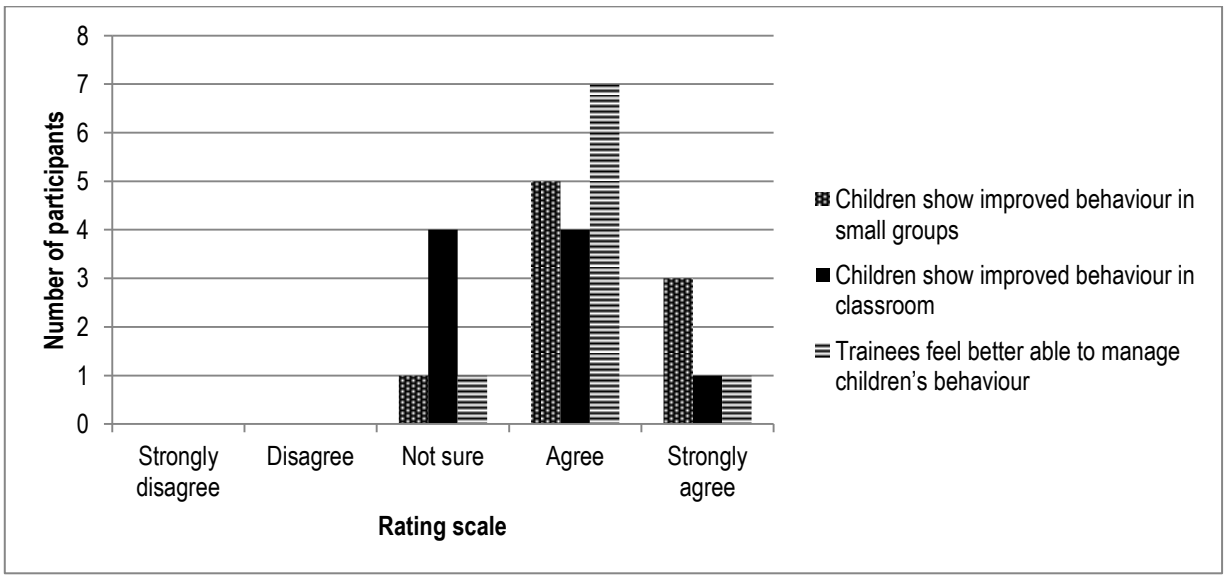

Figure 4: Participants' reporting of how using the newly acquired skills helped improve children's' behaviour

School 1:
• We are limited in time so we must plan the program carefully • Encouraged students' confidence • Helped generally with younger children • Concentration • Instead of everyone doing the same thing at the same time, there were many different things going on in the group. This made it different from anything else they had experienced. They could show themselves at their best here even if they were weak in other subjects • I now have more ability to control hyperactive students • New skill to do job in a better way • I realised it was better to have the hyperactive children and the shy children in different groups. They improved more in this way • It helped me at home with my small children • I used musical activities with whole classes • Used to refocus children during lessons, e.g. making music with pens, etc. • Used techniques to change the mood in classes
School 2:
• The programme needs structure and organisation • It needs a dedicated teacher • It needs a special time of day • We need a special room for the music as therapy groups • Experiential groups were good to release stress personally • It helped me in my work/hobby as singer/musician • I use it in class activities, calming down students • I expected the course would be hard but I found it easy

Table 2: Comments provided by trainees reflecting transfer of skill six months post-training (questionnaire 3)

Evaluation reports; Five months post-training

School 1

To summarise the report, it stated that the children enjoyed these sessions and were eager to have more. The staff had discovered some pupils had musical talent, and also that their ability to stay on task in the music groups and classes increased. The team talked about the pupils developing their own ways of playing the instruments. One person stated:

> "We think that the students' behaviour has changed because the music really is a wonderful way to interact with the students".

Some of the challenges were also indicated; these included how a number of pupils needed a lot of time to settle in the groups; in addition, other school activities meant it was sometimes difficult to hold groups regularly.

School 2

In this report, some of the original teachers had facilitated a few groups. The report stated that:

> "The students' behaviour is improving within the groups compared to how they were behaving within their classrooms".

Staff do say, however, that they are struggling with timetabling and with children missing lessons.

Evaluation reports: Thirteen months post-training

School 1

The reports received in December continued to indicate positive outcomes, although again timetabling remained an issue. This time, extra aims were added into the programme by staff, including "to encourage the pupils" and "to develop mutual respect and broaden their horizons". One teacher devised an activity where they themselves would "make a mistake" so the pupils could correct them. Another new game was to "show the pupils how it feels when they are noisy and don't listen", leading to a discussion about the teachers' emotions. All teachers in the school felt that those involved in the groups showed improved behaviour and engagement. The social worker was also about to commence individual work with one pupil with a view to helping him join an interactive therapeutic music group. One teacher in the programme had left the school, but the social worker was training the new special needs teacher to take her place. In addition to this, a long-term volunteer was being given skills to assist with the groups and potentially facilitate one himself.

School 2

By this time, one of the major challenges for School 2 appeared to have been overcome: a dedicated room for the therapeutic music-making groups. Teachers no longer run any of the interactive therapeutic music groups; these are wholly managed by the social worker. Instruments are stored in the therapeutic music room and used only for these sessions. The report states that pupils are developing their joint music-making through rhythmic cooperation, and this is helping to create a safe space to talk about feelings, to wait their turn and "relieve some creative energy using music as the model". The school believes pupils are learning healthy ways to cope with negative feelings. In School 2, some aspects of the group sessions are devoted to non-musical activities so the tool is not solely music.

DISCUSSION

The purpose of this evaluation was to investigate trainees' motivations to attend the Beit Sahour training programme and the extent to which the training programme met its objectives in upskilling trainees with sustainable tools they can use in the educational setting. To this end, results suggest that all trainees felt the training could be useful to them and were highly motivated to attend, and all indicated that the training had been of a high standard. Understanding the motivations and expectations of trainees proved useful in gauging the efficacy of the training. More specifically, the finding which indicated that motivation and instrumentality remained constant at the start and end of the six-week training programme is testament to the efficacy of the course. Variables, however, are highly malleable and tend to fluctuate as a result of experiences (Tombs 2013). Motivation and instrumentality tend to decrease when trainees are dissatisfied with the training programme; this was not the case here. Satisfaction was indeed high amongst trainees, with all agreeing that the training methods, the materials and the trainers were of a high standard. Thus, considering motivations and expectations as an outcome of training may be more powerful in assessing efficacy than only asking trainees to report their satisfaction. Motivations and good training experiences were therefore a feature of the data gathered, which are the bedrocks for sustainability and efficacy of training (Bhatti et al. 2014).

One of the key advantages of the current evaluation study is the gathering of data at different points in time post-training, enabling examination of actual transfer and sustainability of new knowledge and skills. Qualitative comments provided in the post-training questionnaires and the evaluation reports indicated that some trainees seemed able to use the skills and training in a wider context than simply running interactive therapeutic music groups. They stated that they were using musical activities with whole classes, sometimes to refocus their pupils. Although this was not a primary goal of the training programme, it is an interesting finding and one that has the potential to broaden the remit of further training opportunities. It appears the training had given staff a different perspective on their roles in the school and, possibly, more confidence generally in their work. The reports, especially those from School 1, seem to support this, with staff stating they had made new discoveries about their pupils because they were working with them using music. There are also interesting comments made regarding staff developing and devising their own activities; this appears to show that the skills transferred are being applied in ways that fit the context. It may be argued, therefore, that rather than slavishly following the format demonstrated by trainers of small, interactive therapeutic music groups, skills are being generalised into the teaching programme of the school as well as being preserved in the small group format. Staff felt able to use their new skills in a wider context than simply small groups, demonstrating that transferability of skills is occurring. To this end, findings support previous literature on the usefulness of music in the management of behaviour in the classroom (Derrington 2011; Sutton 2002). It is important to note that no in-depth analysis of which particular activities or general therapeutic principles were considered most useful was undertaken in this evaluation. This might have been useful as it could have enabled any future training input to build on those aspects considered of greatest value to these particular settings. It would also have been helpful for the evaluators to have had clearer information regarding the workshop elements of the training programme. Documentation relating to precise teaching methods, including materials used, may have enabled a fuller examination of the efficacy of the methods deployed to impart technical knowledge.

An interesting finding emerged from the data which indicated that the two schools differed in terms of trainees' reporting on the usage of skills. More specifically, whereas trainees from School 1

provided rich comments about usage of skills, trainees from School 2 mainly focussed on resources and barriers to run the groups. The School 1 team reported that the training had helped them generally in their work. They also made other observations, such as the small groups being a place where "there were many different things going on in the group" which was a new experience for pupils who would normally expect to all be doing the same thing. It was also noted that the pupils "could show themselves at their best here even if they were weak in other subjects". Such comments showed more insight into pupils' needs and a more obvious development in the way the groups were being operated. It was also noted that School 1 were endeavouring to keep a larger team using these skills, and to maintain music as the only tool used in the groups. In contrast, School 2 only have one member of staff using interactive therapeutic music groups meaning that the programme would not be sustainable if this staff member were to leave or to cease running the groups. Comments from staff at School 2 reveal concerns regarding practicalities of running groups, with suggestions made such as a specific teacher being needed to undertake this work.

Given that trainees from both schools were highly motivated to learn and could see the benefits of attending the course, other factors may have played a part in leading to these differences. For example, within the literature on training in organisations, evidence now exists on the impact of the environment in which trainees work on the transfer of training (Bhatti et al. 2014). Many factors work against employees effectively transferring the new skills, particularly lack of support and opportunities provided by line managers and colleagues. At the time the project was delivered, aspects of organisational dynamics or environmental factors that may have played a role in the embedding of skills were not explored. Future projects could possibly consider gathering more information regarding the environment, staffing levels and management structure of the schools to give clear parameters as to what staff resources may be needed to embed the training into everyday practice in other projects.

Some limitations must be noted before drawing conclusions from this evaluation report. To begin with, it may be argued that findings are limited by the use of a small sample size. However, this sample size is typical of MasTInt training programmes. In addition, there is the potential for insider research and evaluation to compromise validity (Kvale 1995), though there are also complex arguments for the usefulness of such work. Reed and Proctor (1995) identify various criteria relating to practitioner research in healthcare settings that can be generalised to insider-researchers in other settings. They state that such research may be focussed on aspects of practice in which the researcher has a high degree of involvement and therefore there is potential for changes in working practice to be effected as a result of the findings of the research. The voices of the participants hold great importance in such work; the relationship of the insider to the participants may in fact enable a higher degree of freedom and authenticity to be present in the data gathered. Others also suggest that insiders have access to a wealth of knowledge that can enrich and enhance the understanding of the data (Tedlock 2013).

Transfer and sustainability of skills were assessed by using self-report questionnaires. The limitation of such a method is well-documented in the literature (Coolican 2009) and future evaluation projects may add value by employing a multi-method approach. This may include obtaining reports from colleagues, line managers, and even the pupils themselves. Others may suggest conducting observational studies to observe daily activities of trainees. Evaluation of similar projects, in addition to continuing to monitor Project Beit Sahour, could be widened by using semi-structured interviews with staff to inform future input; not solely from MasTInt but also from other locally based professionals. Tierney (1996) argues that such interviews could add a richness to the data collected and an authenticity that could inform the support and development of this work. Though these techniques are powerful, they are extremely time-consuming and have ethical implications. For the purpose of this project, the most suitable technique for the participating schools and MasTInt had to be deployed.

Consideration should also be given to linguistic differences that may have affected the answers provided by trainees. The first two questionnaires were administered in English, and it was unclear as to how much of the questionnaire was fully understood. The final questionnaire was translated into Arabic, with the results being translated back into English once the questionnaires were returned. As the final questionnaire required more qualitative responses it was deemed appropriate to use Arabic, as staff may have felt more comfortable writing in their native language. It may be argued, therefore, that administering all questionnaires in Arabic might have given more qualitative answers and therefore provided a richer source of data.

SUMMARY

Despite some study limitations, this evaluation has been able to meet its aims of examining the quality and efficacy of the training programme and to assess transfer of skills. The evaluation report of the training programme has given valuable insights into issues to be carefully considered when offering an interactive therapeutic music skill-sharing programme as outlined above. Whilst findings suggest that trainees were motivated and satisfied with training, post-training evaluation highlighted that transfer of skills was dependent on availability of resources and support post-training. One school maintained and used the skills more than the other and some possible explanations for this are offered. Future projects of this nature should consider the environment in which trainees work and the extent to which it will enable the use of skills in the long-term. In addition, future projects will benefit from an in-depth examination of the actual training to ascertain whether issues of transfer and sustainability may be associated with the delivery of training itself. Although the booklet provided some information in relation to this, no information was obtained regarding content of training sessions or workshop plans. This, together with data regarding use of specific activities by trainees, and data concerning which theoretical concepts trainees deemed most useful, may have given evaluators added insight as to whether the training could have been further refined to maximise relevance to each specific environment. Further evaluative work of this nature is required in order to fully understand the conditions and factors that can be leveraged during and after the training programme to improve transfer and sustainability of training.

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The authors would like to thank Music as Therapy International (MasTInt) and the Evangelical Lutheran Church in Jordan and the Holy Land (ELCJHL) for their support of the project. They also gratefully acknowledge research funding for the study from the Centre of Excellence in Learning and Teaching (CELT) at the University of South Wales. We would also like to thank other members of the research team who assisted in the collection of data, namely: Hazel Child, Teleri Dyer, Naomi Rowe and Eleni Tsolka.

APPENDIX

Items comprising the measure of motivation to learn

1. I am excited to have the opportunity to learn new skills.
2. I will try and learn as much as I can during this training.
3. I am motivated to learn the material during the training.

Items comprising the measure of instrumentality

1. This training will teach me how to work more effectively in my job.
2. I will learn new skills that will improve my general skill level.
3. This training will help me approach my work in a different way.
4. I do not understand how this training will help me work more effectively (Reversed).

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Article

A voyage of discovery: From fulfilling funding criteria to revealing a clearer vision for music therapy in a special needs school

Claire Cartwright

ABSTRACT

In the era of the evidence-based practice (EBP) movement, music therapists are increasingly asked to provide evidence for funders. Often this has been the requirement to "evaluate existing services, or to justify the creation of new services with 'appropriate' evidence" (Pavlicevic, Ansdell, Procter & Hickey 2009: 3-4). Youth Music Initiative|Creative Scotland (YMI) awarded funds to Nordoff-Robbins Music Therapy in Scotland to support music therapy services for a number of schools in a local council area in Scotland. As part of this funding, they requested a service evaluation of one of these schools. The first part of this paper describes this evaluation (conducted in 2013) of the music therapy service in a school for pupils with complex needs. The evaluation aimed to assess the impact of music therapy on the pupils and the school and to ensure the quality of the service. The second part of the paper discusses the process of meeting an additional request from the funders which came after the completion of the evaluation. This time, all of the schools under the umbrella of this funding block were each asked to provide information to prove eligibility to access this funding to ensure funding renewal. Case studies and the evaluation findings are used to help illustrate how music therapy meets the funder's goals. This process led to the development of a model for a continuum of music provision in the school. This paper aims to demonstrate how the funding journey not only ensured the continuance of music therapy but actually resulted in a clearer vision of the role of music therapy in the school.

KEYWORDS

music therapy; funding; vision; service evaluation; music education; complex needs

Claire Cartwright is originally from Ireland. She plays piano and clarinet and has a background in teaching clarinet, recorder and music theory in primary schools and a concert band, where she was also musical director of the Junior Band. Claire achieved her B.Mus in 2008 from the National University of Ireland, Maynooth. Claire then graduated with an MSc Music Therapy (Nordoff-Robbins) from Queen Margaret University, Edinburgh in 2011. Claire has been working with Nordoff-Robbins Music Therapy in Scotland since August 2011. Her clinical experience includes working with children and adults with autism spectrum disorders, learning disabilities, mental health issues, and sensory impairments.

Email: clairecartwright@nrscot.org.uk

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INTRODUCTION

Music therapy in the 21st century continues to grow and prosper. However, funding is as ever an integral factor in the establishment and continuation of music therapy services. Funders increasingly require evidence of the quality of the service and confirmation of how their funding criteria are being met (Miller 2014). This is something we, as music therapists, need to engage with so we can continue to provide music therapy to our clients. However, the process of evidence gathering can be time consuming and is often met with apprehension by practitioners. In fact, in 2004 Pavlicevic, Ansdell and Procter published *Presenting the Evidence: A Guide for Music Therapists Responding to the Demands of Clinical Effectiveness and Evidence-Based Practice* in response to the increasing anxiety and pressure felt by our profession to "demonstrate the value of the services they provide, or to justify with appropriate 'evidence' the creating of new services" (Pavlicevic et al. 2004: 4). At times it can feel as if we are being asked to categorise, define and present music therapy in ways that do not feel altogether satisfactory. In the evidence-based practice (EBP) movement, one of the most highly regarded methods of measuring effectiveness is randomised control trials (RCTs). Qualitative methods, on the other hand, feature at a lower level in hierarchies of research standards (Pavlicevic, Ansdell & Procter 2004). Yet it is encouraging that qualitative research is beginning to gain more credibility, as discussed in the second edition of *Presenting the Evidence* (Pavlicevic et al. 2009) e.g. the government's report *Quality in Qualitative Evaluation* report and the recently set-up Campbell Collaboration which "[…] can be seen as the counterpoint to the Cochrane Collaboration, with its framework and protocols for systematic reviews of qualitative research evidence […]" (Pavlicevic et al. 2009: 16). However, RCTs are still widely considered one of the gold standards but are not easily undertaken in music therapy research for a number of reasons including the large sample size needed and the nature of improvisation in many music therapy models which means difficulty in replicating studies (Pavlicevic, Ansdell & Procter 2004). Some music therapy researchers are exploring RCTs (Erkkilä et al. 2011; Geretsegger & Gold 2012; Gold et al. 2014; Porter et al. 2012; Rolvjord, Gold & Stige 2005). However, such research projects require a lot of time and resources, and they are not generally feasible for those with busy clinical workloads when asked to provide evidence to funders. There is often little time available outside the actual service provision and we may only have access to a small client base as a sample size. Therefore, evidence out of necessity must occur on a smaller scale.

This article hopes to demonstrate that by undertaking to provide evidence for funders and meet their requirements, music therapists might not only fulfil the needs of the funders but also gain further insight into their own clinical work. This article illustrates how my journey into meeting funding criteria led to a clearer vision of the role of the music therapy service within a school.

This journey began when Youth Music Initiative | Creative Scotland (YMI) awarded funds to Nordoff-Robbins Music Therapy in Scotland to support music therapy services for a number of schools for pupils with additional needs in a local council area in Scotland. As part of this award, YMI requested an evaluation of the service at one of the schools they were funding as an indicator of the quality of work and the impact of music therapy on the pupils. An evaluation study is one of the achievable strategies outlined for practising clinicians to meet the demand for evidence which is "geared explicitly to give a value judgement on the music therapy service" (Pavlicevic et al. 2009: 44). Examples of other evaluation studies in music therapy include Moss (2003), Powell (2006), Rowland and Read (2011), Lawes (2012) and Foster, Wiseman and Pennert (2014).

The evaluation was chosen to take place at a school which caters for pupils with sensory impairments and complex needs, for which YMI were part-funding the music therapy service. The school in question is a co-educational, inter-denominational school catering for children and young people aged 2-19 years old. Most pupils have a visual and/or a hearing impairment. Pupils also have additional learning difficulties and/or complex needs. The school has a vibrant music department and a number of on-site specialists amongst the multi-disciplinary team including nurses, physiotherapists, a speech and language therapist, a visual impairment specialist, a hearing impairment specialist, a mobility specialist and so on. The school also offers a range of therapies including rebound therapy, massage therapy and equine therapy.

The school has had a music therapy service since 2011. Funding has come from a variety of sources and with that, service input has increased from an initial 4 hours to 8 hours. The service is provided over 2 days. I provide a combination of individual music therapy, work in pairs and some small groups. The number of individual and group

sessions varies according to referrals and needs of the pupils. Due to the complex learning, physical and medical needs of many of the pupils, there are often staff members present in sessions. As well as support staff accompanying pupils, teachers or specialists have sometimes sat in to observe and nurses have often been in and out to deal with medical needs. Therefore, a large number of staff have direct experience of music therapy. At the time of the evaluation, there were 19 pupils attending music therapy: 4 individual sessions, 4 groups of two, 1 group of three and 1 group of four pupils.

The first part of this paper details the evaluation process and sets out its findings. This evaluation was carried out as part of the conditions of receiving funding for a number of schools but is specific to the school in question as requested. The evaluation is communicated here as one part of the overall process of meeting funding criteria.

A few months after the evaluation, when considering funding renewal, the funders requested further information to illustrate how music therapy was eligible for this source of funding. The request was made across the board to all of the council schools receiving funding from this award (including the school where music therapy had been evaluated). This request was separate to the evaluation which was not about funding eligibility but rather about the impact of music therapy. The second part of this paper therefore deals with how this request was met. It outlines the three aims of the funding body and discusses how I, in collaboration with the music specialist, set out to explain how music therapy could meet those aims. Both case studies and the findings of the evaluation are utilised to support the case of music therapy as an appropriate means of achieving these aims. The discussion around the aims also resulted in the creation of a model of a continuum of music provision in the school, enabling the full potential of the music therapy service and of the pupils to be achieved. It is hoped that this proposed continuum of music provision can be of use to others working in settings with a variety of musical inputs, as a means for helping identify the roles of these different provisions.

PART 1: SERVICE EVALUATION

Aims of the evaluation

The purpose of the evaluation was to assess the impact of music therapy on the pupils and the school as a whole. The evaluation also aimed to ensure the quality of the service and identify areas for improvement.

Evaluation design and method

The evaluation sought to explore the impact of music therapy from the viewpoint of staff and parents. Due to the complex nature of their communication needs, it was not possible to get pupils' feedback. There would have been time constraints associated with meeting staff and parents individually for interviews or through focus groups. Also, as I was in the dual role of music therapist and evaluator, it may have proved difficult for staff and parents to answer questions openly. Therefore, a questionnaire seemed the most appropriate method of data collection in order to reach a wider number of participants, as well as to generate more honest answers and to ensure anonymity. A questionnaire would also have taken less time for participants to undertake and could be filled out at their convenience. Sampling was purposeful due to the necessity of targeting parents whose child had experienced music therapy and staff who were working in the school where music therapy was being provided.

Due to the different kinds of involvement with the music therapy service, two questionnaires were designed: one for staff (Appendix A) and one for parents (Appendix B). The staff questionnaire was based on a previous evaluation project for a different school which was carried out by another member of the Nordoff-Robbins Music Therapy in Scotland team. This previous project included the same type of aims as the one currently being discussed. This also meant that the questionnaire had been trialled before and proved a useful method of collecting data. Some questions needed minor alteration in relation to the context of the school. In the previous evaluation study responses were collected from pupils (not parents), as the communication abilities of the pupils enabled them to give appropriate feedback. However, as this study included parent responses instead, I designed a separate parent questionnaire accordingly.

Questions intended to assess the impact of music therapy on the pupils were the same in both staff and parent questionnaires. Warm-up questions differed (due to context) and questions with the purpose of understanding quality of the music therapy service (particularly in relation to communication with myself as the therapist) were different in the two questionnaires, as the forms of

contact I had with parents and staff were not the same. The language and construct of each question in both questionnaires was carefully assessed to avoid leading the participants towards certain answers and to provide opportunity for both positive and negative comments. I also shared draft versions with my line manager, the regional head music therapist at Nordoff-Robbins Music Therapy in Scotland and the head teacher at the school, to ensure the clarity and structure of the questionnaires.

The questionnaires used a combination of open and closed questions. The closed questions gave the opportunity for numerical data, which could provide concise results for the funders and a broad overview of the impact of music therapy and the quality of the service. The open questions provided room for narrative data in order to better understand the impact of music therapy through the experience of the staff and parents and to allow suggestions for improvement. This resulted in a rich corpus of data.

Data collection

Staff's and parents' questionnaires were made available electronically via SurveyMonkey. Paper copies of the staff questionnaire were also available from the school reception. Although this meant the questionnaire was available to all staff who had access to the reception, it is unlikely staff without direct knowledge/experience of the music therapy service could have answered the questionnaire. Paper copies of the parents' questionnaires were posted out. One copy was sent per household. However, in hindsight, two copies could have been sent to gain the perspectives of both parents – where applicable. Participants were given information about why the evaluation was taking place and how results might be used. Participation was voluntary and anonymity was ensured. Descriptive statistics and thematic analysis were used to analyse the collected data.

Limitations

1. The evaluation results are localised to this service and due to the small sample cannot be generalised.
2. Participants' awareness of the evaluation aims may have influenced their views. However, answers appear genuine, stemming from actual events and many (in particular with regard to areas of impact) can be confirmed via clinical notes and video recordings of sessions. Gaining the view from both staff and parents also acted as triangulation.
3. On SurveyMonkey, questionnaires were set to allow only one response per computer. However, due to paper copies being available too and the paper copies not being individually handed out, there was potential for duplicate responses. Although, this did not seem apparent during analysis as the combination of answers varied.

Description of respondents

Staff

There were 30 members of staff who either worked with a pupil who attended music therapy, or had experience of music therapy through observing or attending sessions with pupils. It is unlikely that staff would have completed the questionnaires without direct knowledge or experience of the service; therefore this was taken as the probable number of staff who could have answered the questionnaire. Fifteen members of staff returned questionnaires (Figure 1) giving a response rate of 50% (77% were paper responses and 23% by SurveyMonkey). The majority of the respondents (87%, n=13) had either accompanied pupils to music therapy or observed a session. It is possible that their more direct involvement motivated them to take part in the evaluation project. It also allowed them to give insight based directly on their observation of pupils' responses. The remaining 13% (n=2) worked with a pupil who attended music therapy and had met me in relation to a pupil's progress in music therapy. Almost half of respondents (47%, n=7) had also attended a music therapy presentation for staff.

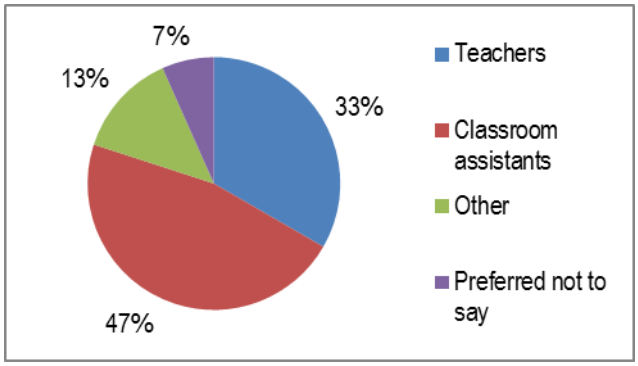

Figure 1: Designation of staff respondents

Parents / carers

There were 19 pupils who attended music therapy at the time of this evaluation. Of these, 9 parents/carers responded, giving a response rate of 47%. All responses were via paper questionnaire copies.. Of those who responded, 77% (n=9) had previously attended a music therapy feedback meeting (which included video extracts of their child's sessions), perhaps suggesting that more contact with the service and with me motivated parents to take part in the evaluation project or helped them to feel they could contribute more to the questionnaire.

Findings

Music therapy's impact on pupils

Figure 2 outlines the perceived general impact of music therapy on the pupils according to staff and parents.

In addition to this, 100% (n=9) of parents wanted the music therapy service in the school to continue. (This question was not included in the staff questionnaire due to limitations of number of questions and restrictions of free version of SurveyMonkey).

Table 1 outlines the key areas of impact identified and provides examples of quotes pertaining to each area.

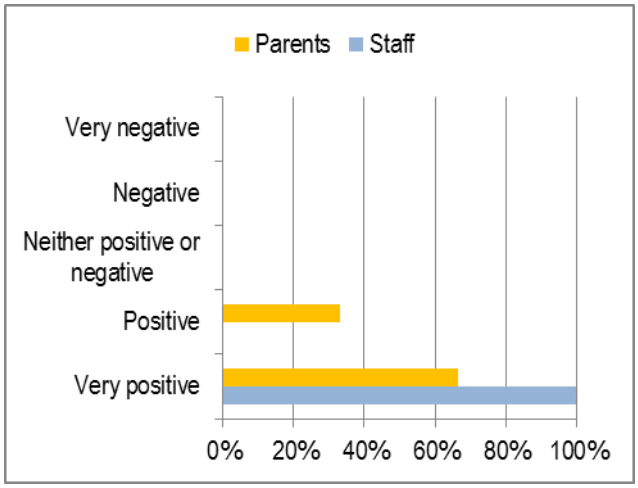

Figure 2: Impact of music therapy on pupils

Key areas of impact	Examples of quotes
Confidence	"The children I accompanied to a session have got more confident and respond a lot more to music" (Staff).
Focus	"Definitely more focussed" (Staff).
Responsiveness	"Both children who attend respond really well to the music session. There are times when sometimes they are sleeping and as soon as the therapist starts playing the hello song both children smile. Children become quite vocal when the therapist asks them to sing." (Staff). "See children reacting differently during music therapy sessions" (Staff).
Developmental skills	"Some of our most physically challenged pupils [show] reactions and make movements outwith their normal range to gain the musical reward" (Staff). "If the children are happy, content, and reaching developmental milestones like touching to explore, grasping and holding and turn-taking then an activity like this is worth its weight in gold" (Staff).
Emotional impact i.e. relaxed, peaceful, happy, enjoyment	"I know my daughter enjoys music therapy from the feedback I have received from teachers and looking at videos, she seems to get pleasure and enjoy her time there" (Parent). "...the chance to experience something innately pleasurable and relaxing" (Parent). "Children whom appear a little distracted generally within their school day tend to relax and appear peaceful" (Staff).

Motivation/ anticipation	"This pupil can be very reluctant to go to certain activities but he is always keen to go to music therapy which is a very good indicator that he enjoys it" (Staff). "Music therapy plays a huge part in the children's life within my class, they all enjoy it very much and look forward to it each week" (Staff).
Self-expression/ communication	"Music therapy allows my child to express themselves. As they are non-verbal this is hugely important" (Parent). "It provides the pupils freedom to express themselves with no restrictions" (Staff). "Music therapy provides my son with *so much fun*. He is able to communicate non-verbally for more or stop by using facial or body expressions. Music is such a big part of our family life and ... it has taught us how to cope with many of my son's highs and lows" (Parent).
Turn-taking	"Pupil has become more aware of turn-taking. He patiently listens to other children play and reaches out when his name is said to find the instrument" (Staff). "A pupil who came to the school who was unwilling to take turns has learned to wait and anticipate when the therapist is working with him" (Staff).
Self-belief and self-esteem	"It makes them feel good about themselves" (Parent). "Music therapy is invaluable to children with sensory needs and the experience is life enriching, providing the child with self-belief" (Parent).
Experience of new sounds and instruments	"It provides an environment where fantastic musical instruments are accessible to my daughter that she wouldn't normally have access to" (Parent).
Vocalisations/use of voice	"A number of the children have been very vocal during sessions" (Staff). "With two children they have learned to use their voices. Another child also often makes sounds in the key and intonation which the therapist has used" (Staff).
Choice-making	"Helps with their everyday skills, i.e. choosing" (Staff). "Pupils confidence in self-expression when choosing and playing instruments" (Staff).
Motivation for exploration of instruments and moving out of comfort zone	"One pupil never liked leaving the piano, but as the weeks progressed more and more time was spent with other instruments which is a huge achievement" (Staff).
Listening skills	"One pupil is putting her hand up more and more regular when she hears her favourite instrument. She is bringing it back and doing it in class too" (Staff). "He patiently listens to other children play and reaches out when his name is said to find the instrument" (Staff).
Transference of skills from music therapy to other situations	"[We have] a pupil who would not touch or explore items [and has now] begun to play a tambourine independently. This skill has transferred [out of sessions] to him willingly exploring and tapping/touching other media like the iPad, switch-it work, and sensory exploring of other materials" (Staff). "This pupil would not hold onto items for a few months but has begun to hold onto a shaker in music therapy which has transferred to other areas" (Staff). "I have witnessed pupils previously reluctant to any involvement in a 'normal' music lesson become and develop their confidence to use instruments of their choice – this in turn has transferred to class music sessions" (Staff).

Table 1: Key areas of impact and supporting quotes

Music therapy's impact on the school as a whole

Staff and parents highlighted what they felt music therapy provided that was unique within the school including how it engages pupils, how it provided children with the opportunity to express themselves, how it gives them more choice and provides them with enjoyable experiences. They also mentioned that "The one-to-one specialist input is very valuable and beneficial for certain pupils" (Staff) and highlighted the person-centred nature of music therapy: "The therapist's approach to the children is all very individualised to the child's needs" (Staff).

In addition, staff noted that music therapy provides a "contrasting experience to that of a music lesson". For pupils who found it difficult to partake in other musical inputs, the specialised approach appeared to help them to access music and give them confidence in doing this:

> "These sessions are different from other music activities because they give the children the time to take the lead. The musical tasks that are asked of them are simple and at their own level, which gives them more opportunity of succeeding" (Staff).

> "I have witnessed pupils previously reluctant to any involvement in a 'normal' music lesson become [sic] and develop their confidence to use instruments of their choice – this in turn has transferred to class music sessions" (Staff).

A couple of staff felt that in some ways it was difficult to class music therapy as unique, with one staff member saying:

> "the school offers a range of therapies which address communication, confidence and self-esteem. Music therapy is part of a suite of interventions evaluated and selected to support teaching and learning" (Staff).

Another staff member also told how music therapy provides:

> "[…] enhanced opportunities for our pupils to lead their own learning and experience a greater variety of instruments".

These quotes show that music therapy supports and fits with the overall values of the school and can work alongside the various learning opportunities and therapies that the school provides.

> "The music therapy service fits effortlessly into our educational ethos" (Staff).

Both staff and parents demonstrated the value they placed on music therapy being a part of school life:

> "Music therapy plays a huge part in the children's life within my class, they all enjoy it very much and look forward to it each week" (Staff).

> "Nordoff-Robbins [Music Therapy in Scotland] is a fantastic organisation that does wonderful work that makes a huge difference to the people it teaches. Thank you." (Parent).

> "We are proud to say that Nordoff-Robbins [Music Therapy in Scotland] plays a weekly part in our son's schooling and are so grateful for that. The therapist is fantastic with all the children and so many happy times will be had, by singing and by having fun. Thank you" (Parent).

Two thirds of the staff (67% n=13) felt that they had learned something that could be applied in their own work. As mentioned previously, staff often sat in on sessions and these are therefore learned experiences as opposed to information provided to them. Four main learning areas seemed to be apparent as illustrated in Table 2.

The data in Table 2 shows a positive impact on the school as a whole in what music therapy provides, how it fits within the school's other inputs and how observation of music therapy has influenced the awareness of certain things for staff that can be transferred to other aspects of school life.

Quality of the music therapy service

In relation to the provision of the service, staff felt that the "approach is all very individual to the child's needs. She [the music therapist] has a very calm approach" and that sessions were provided "in a relaxed but professional manner". They also stated that sessions have been "great" and that "the therapist is a wonderful music therapist and all the pupils love attending her music therapy sessions". Figure 3 shows the levels of satisfaction amongst staff relating to different indicators of the quality of the service.

Key learning areas for staff	Example of quotes
Give pupil more time to respond	"I have been reminded to give the pupil more time to focus at his/her speed" (Staff). "To give children more time and leave them to choose themselves" (Staff). "By giving a child longer to process your request and using your imagination to position instruments, they are more likely to play independently" (Staff).
Awareness of environment	"How important it is to have a quiet environment with no distractions" (Staff). "Not to be afraid to be hands-off for a long period of time with the pupils to let them process the environment and respond to it" (Staff).
Use of voice	"Singing more to children can get good responses" (Staff). "One child made use of his voice when trying to play a kazoo. This encouraged staff to look at other ways of encouraging his voice production" (Staff).
Learning what children respond to	"It has provided us with examples of different sounds which our pupils responded to in a positive manner which can be transferred to other learning experiences" (Staff).

Table 2: Key learning areas for staff

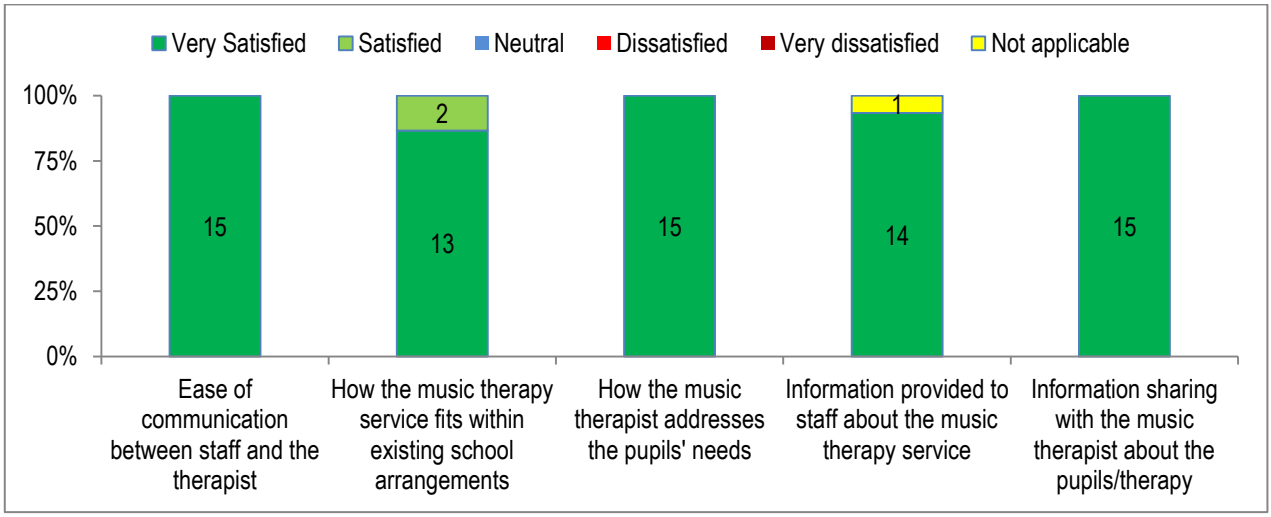

Figure 3: Staff satisfaction with the quality of the music therapy service

Parents were either "very satisfied" (67%, n=6) or "satisfied" (33%, n=3) with the written reports they received about their child's music therapy and 100% (n=15) were happy with the frequency of these reports. Of the 6 parents who had met with me at a parents' evening, 83% (n= 5) found this meeting very beneficial and 17% (n=1) found it to be of some benefit. Those parents who had not had a meeting expressed interest in doing so at a future opportunity.

Although opportunity was given in staff and parent questionnaires to provide both positive and negative answers, questions were designed not to lead one way or the other and participation was anonymous. There were no criticisms of the music therapy service. It is possible that participants were biased or reluctant to provide negative feedback as they were aware the evaluation would provide information to funders. However, all of the information above demonstrates that both staff and parents were satisfied with the quality of the service.

Suggestions for improvements to the music therapy service

There were no areas of difficulty or concern identified by either parents or staff. The improvements mentioned by staff seemed to re-affirm the positive feelings towards music therapy with 5 staff wanting more music therapy input throughout the week:

> "No improvements, just more sessions during the week as all the children benefit from music" (Staff).

> "Have more sessions during the week as they [pupils] really respond to it" (Staff).

One staff member also asked for videos to be shared with class staff. As mentioned above, parents did not feel the need for any improvements with communication. One parent commented on what would be beneficial if the service continued:

> "If therapy continues over an extended period, my child will benefit from consistency of staff and approach as this will maximise his ability to access his sessions" (Parent).

One parent who had experience of a music therapy open day wrote:

> "I enjoyed the open day and I'm sure a lot of parents or carers would learn a lot. Maybe a parents' support group led by Nordoff-Robbins [Music Therapy in Scotland] would be useful, but seeing the children first hand works best".

Summary of evaluation findings

The results demonstrate the highly positive impact that music therapy has on the pupils, both in sessions and outside sessions. They show that music therapy helps pupils to access music who have difficulty accessing other musical input and that the one-to-one specialist approach is very beneficial for some pupils. Music therapy was deemed to have a positive impact on the school as a whole in what it provides, how it fits within the school's other inputs and how observation of music therapy has influenced staff's awareness of techniques that can be transferred to other aspects of school life.

PART 2: MAKING A CASE FOR ELIGIBILITY TO ACCESS FUNDING SOURCE

A few months after the evaluation, all of the music therapists working in the schools funded by YMI were asked to provide information to demonstrate the relevance of music therapy in relation to the intentions of the YMI programme. Whereas the evaluation was requested to discover the impact of music therapy when they provided the initial funding, now YMI were wanting further information across the board in order to prove the appropriateness of this funding source so as to justify the continued funding of the services the following year.

This part depicts how I endeavoured to meet this requirement in relation to the school discussed in this article. In seeking to address this I started with their three main aims as outlined on the YMI website (2014):

Aim 1: Create access to high quality music making opportunities for young people aged 0-25, particularly for those that would not normally have the chance to participate.

Aim 2: Enable young people to achieve their potential in and through music making.

Aim 3: Support the development of the youth music sector for the benefit of young people.

While the evaluation provided an excellent source of data (and I return to this later), it was necessary to examine the music provision already existing in the school and to assess why music therapy was needed to achieve the above aims in this school. In order to do this I met with the music specialist. We already kept in close contact for feedback purposes and the music specialist had previously observed some music therapy sessions. This had led to the increased awareness of the music specialist of the potential of musical improvisation after observing the responses and engagement of a pupil during improvised music in music therapy. This had resulted in the music specialist creating an improvisation group. Other performance groups the music specialist ran included a pop/rock band and a samba band. The music specialist was also involved in the delivery of music classes to the pupils (as were other members of the staff).

As part of a funding allocation to training, I provided further information on music therapy to the music specialist. We shared our approaches with each other in order to understand where the differences and similarities between our work lay. We discussed how music is often the goal in education/performance situations, whereas music is part of the process in music therapy as opposed to being the goal. In music therapy, music is the tool through which to achieve non-musical goals and outcomes. Robertson (2000: 41) deliberated upon the following notion that

> "[…] *the notes between* (the expression, the experience, the essence) are particularly relevant to the music therapy process, and *the notes* themselves (the theoretical, the tangible, the taught) are the *raison d'etre* of music education" (Robertson 2000: 41).

However, Robertson argued that this distinction,

although clear, could also be viewed as "too simple". We also felt that the difference was only part of the picture. We discussed some overlapping areas e.g. that some aims of music therapy (e.g. increasing confidence, developing social skills, etc.). can also be a by-product of music education/performance experiences. In some ways our discussion helped to clarify our respective roles in terms of music input within the school. Yet in other ways it raised more need to explore our professional roles further and if there were any links to be made. Robertson (2000: 42) raised the question "Is the music therapist working in special education in danger of being sidelined?". Indeed, Pethybridge (2013) discussed how allied health professionals in educational settings are being encouraged to find ways of meeting therapeutic needs with less actual contact time with pupils. In evaluating partnership working by involving nursery staff in a music therapy group, she found "[…] the flexibility of the music therapist in direct work is highly specialised and cannot be easily replicated in other classroom music activities" and also that partnership working can "[…] offer some level of transferable learning for teaching and support staff and potential for developing more indirect approaches […]" (Pethybridge 2013: 24). This also seemed evident in the school we were working in, as discussed earlier under what staff had learnt from sitting in on music therapy sessions.

As the discussion of our roles continued, we examined the various music-making opportunities in the school (the groups mentioned above) and how some pupils were not able to access them due to their difficulties. It was also recognised that for some pupils, class music-making sessions were not able to offer the individualised and specialised attention needed to realise the pupil's full potential. It was felt that for these pupils accessing music needed to be approached with more than just the music in mind. It was here we felt music therapy came in.

After this discussion with the music specialist, I decided to look at each aim of the funder in turn to provide information pertaining to the relevance of music therapy to that aim. I was then able to use case vignettes in conjunction with data from the evaluation to provide support for the fulfilment of each aim.

Aim 1:

> "Create access to high quality music making opportunities for young people aged 0-25, particularly for those that would not normally have the chance to participate" (Creative Scotland 2014).

As the school catered for pupils aged 2-19, the pupils were within the correct age bracket. In terms of the high quality music making opportunities I was able to draw on my training as a music therapist to meet this aspect. All professional music therapists hold a postgraduate qualification, with the entry requirements to the training courses requiring a high quality of musicianship (Nordoff-Robbins Music Therapy in Scotland 2014). I was trained to create and improvise music with clients in an interactive and therapeutic way as outlined under the Introduction to MSc Music Therapy (Nordoff-Robbins) (Queen Margaret University 2014) where I qualified.

In terms of creating access for those that would not normally have the chance to participate, as identified earlier, some pupils were having difficulty accessing the other music provisions in the school. These pupils were often referred to music therapy. I highlighted the fact that as a music therapist, I work in a way that is person-centred and led by the pupil, working in an interactive, response-led style. The music is used as a tool to help remove the barriers that prevent the pupils from participating (e.g. confidence, interaction skills, communication skills, physical limitations, developmental limitations, listening skills, awareness of self and others, and ability to focus). By using the music to develop these skills and areas, the pupils in turn were then more able to access music. Looking at the key areas of impact for pupils that were highlighted in the evaluation it can be seen that music therapy is making progress in these areas (Table 1).

There are also environmental aspects to consider: music activities/classes tended to be in bigger groups, often proving too overwhelming with too many distractions for pupils. Music therapy takes place in a quieter environment that gives more space for the pupils to respond free from distractions where I respond to what the pupil is doing, therefore encouraging meaningful and purposeful engagement with the music. This was also backed up by comments from the evaluation (Table 2). The following case study is an example of how music therapy fulfills aim 1.

Case vignette example of how music therapy allows a young person to access and participate in music

Pupil A (age 13) has a visual impairment and complex needs. When she began music therapy at age 10 she had very little awareness of her environment, herself or others and there was very little that she responded to. I worked on developing awareness of self and self and other, for example through playing with the tempo of her breathing (which elicited a response of awe) and introduced her to different sounds, initially through co-active playing. Over time the pupil's listening skills improved and she became more aware of my music and responses. She began to show interest in a variety of sounds and instruments. Gradually she began to understand that she could have an effect on her environment and that she could produce sounds from the instruments through her own movements (e.g. when using bells on her wrist she became aware of her arm as part of herself and that by moving it the bells elicited a sound). She will now reach out to independently play some instruments as her understanding of cause and effect has improved (e.g. windchimes, cabasa, nutshaker). Music therapy has worked at removing some of the barriers to her participation in music and she is now accessing music in a way she was unable to before.

As illustrated above, music therapy gives the pupils who have difficulty accessing music under the other music provisions the opportunity to access high quality music making opportunities in a setting that is more conducive to their needs. As one staff member mentioned:

> "I have witnessed pupils previously reluctant to any involvement in a 'normal' music lesson become [more confident] and develop their confidence to use instruments of their choice – this in turn has transferred to class music sessions".

Aim 2:

> "Enable young people to achieve their potential in and through music making" (Creative Scotland, 2014)

I felt that there were two parts to this aim that I needed to address – how music therapy enables young people to achieve their potential *in or through* music making. It seemed that case studies of pupils were the most appropriate means of showing how music therapy was achieving this. It can help them to achieve their potential *in* music making by increasing the accessibility of music and enabling them to make progress musically which the following case study demonstrates.

Case vignette example of achieving potential in music making

Pupil B (age 10) has a visual and hearing impairment and complex needs. She had difficulty focusing or engaging with her environment. Her hearing impairment amongst other issues made it difficult for her to access music. In music therapy, we have been able to learn more about her hearing skills, develop focus, awareness and encourage her to access instruments. Musically, she now explores rhythm, patterns and pulse and is also developing melodic and harmonic awareness. She is also beginning to participate more in class music sessions.

Case vignette example of achieving potential through music making

Pupil C (age 7) has complex physical and learning needs and is registered blind. As mentioned in the evaluation he:

> "[We have] a pupil who would not touch or explore items [and has now] begun to play a tambourine independently. This skill has transferred [out of sessions] to him willingly exploring and tapping/touching other media like the iPad, switch-it work, and sensory exploring of other materials" (Staff).

The therapeutic work in sessions through the medium of music is enabling him to more fully reach his potential both in music therapy and in other situations.

Aim 3:

> "Support the development of the youth music sector for the benefit of young people" (Creative Scotland, 2014).

This was the aim that required the most discussion as it is not an aim often associated with music therapy. I spoke with the music specialist to look at whether music therapy was contributing to this aim. In the end this was the aim which proved most beneficial in furthering both my own and the music specialist's insight into the roles of the different school music provisions and how they linked together. It ultimately culminated in the

development of a model of a continuum for music provision in the school which could offer guidance and information as to what type of music input was most appropriate and why. Our thinking and foundations for this idea developed from the following case example.

Case vignette example of a pupil who progressed from music therapy to a performance group

Pupil C (age 15) is registered blind, has autism and is non-verbal. He could not cope with class music sessions and struggled to participate in them at all. Through individual music therapy sessions he gained confidence in interacting musically, gradually increased the number of instruments he explored and played, and developed his listening skills. He was able to follow the rhythm or pulse of a piece of music, play simple and more complex rhythms, explore a range of dynamics, tempi, different time signatures (4/4, 3/4 and 6/8) and follow and initiate changes in the music. He loved to improvise and seemed to gain great joy from it. He went on to join the school's samba group and coped very well with this. At first he continued to attend both therapy sessions and the samba group. He then moved to finishing music therapy and just attending the samba group. He has performed at a number of occasions with the group, contributing to the youth music sector.

In music therapy both the therapeutic need and musical need can be worked on and indeed they are often interlinked. However, the pupil may reach a stage where the goals of music therapy have been achieved and where music therapy is no longer required. However, the pupil may still have a love of music and would benefit from an avenue through which to explore his/her continuing musical needs. This encouraged us to look at how music therapy outcomes could help enable pupils to access the school's performance groups. The groups perform for various events at school and in the community and have performed in a national youth music festival, thereby contributing to the youth music sector.

Already existing within the school was the school's rock band. The band consists of pupils with additional support needs, mainstream music students, volunteer musicians and experienced and professional musicians. The band rehearses and performs regularly to a very high standard. In addition, there was a samba group created for younger pupils who showed musical potential. As mentioned earlier, in response to the observed impact of improvised music in music therapy, the music specialist also established an improvisation group. We looked at this as a possible natural progression for some pupils from music therapy and a starting point for other pupils in the school who did not attend music therapy. As we discussed the potential of pupils to perhaps move on from music therapy to one of the school's music groups, another group was formed – a pre-samba group, with the purpose of being a transition group to build on skills from music therapy to allow the pupils to access the samba group.

Continuum of music provision: An emerging model

As the music specialist and I discussed these possibilities, we realised we wanted to create a model that took into account all of the musical inputs in the school as part of a continuum of music provision. The aim was to demonstrate potential avenues of progression where appropriate, while acknowledging that for some, one area would remain the most suitable musical input for that pupil and to value their contributions without the need to say they must access other inputs to achieve their potential. It was also necessary to acknowledge that a particular therapeutic need may exist or continue in spite of musical skills and that a pupil could access more than one input simultaneously for different reasons. After our discussion, I created the model below (Figure 4) to provide a visual representation of the discussed continuum and to provide clear guidelines as to why a pupil would access one input over another (or indeed multiple inputs).

This model begins at the level of all pupils receiving music education in class. If this is deemed sufficient, then no additional input is offered. However, if in class the pupil is having difficulty accessing music and staff feel a more individualised approach would be beneficial, then they are referred to music therapy. Other reasons for referral to music therapy come under the more traditional areas of communication/interaction, emotional exploration, developmental work and personal growth. The music therapy input they require (e.g. individual/group work) would be determined through assessment of need and the aims of the work. A pupil also may subsequently in time move from individual sessions to paired sessions/small group.

Returning to the level of music in class, if it was felt a pupil was showing musical potential and could benefit from being challenged more in a

performance-orientated outlet, they would then access one of the school's performance groups. Which group they would access would depend on individual skill and need, and be determined by the music specialist. Pupils would have room to subsequently progress through the groups if and when appropriate. Similarly if a pupil in music therapy had achieved their therapeutic goals but would now benefit from continuing to explore their musical potential, they would then have the option of accessing the school's performance groups. The model also gives the option that a pupil may need to access both types of input. For example, a pupil might be very musically-skilled and able to access the performance groups to pursue their musical potential. However, the same pupil may be in need of some emotional support in a therapeutic environment.

It was hoped that this model would make the roles of the different musical inputs in the school clearer for everyone involved and offer guidance to staff for putting pupils forward for one input or another. Perhaps the continuum may prove useful for other music therapists working alongside other musical inputs in special education settings, as a means of demonstrating the need for different musical inputs and how they can support one another. It is recognised that different schools have varying levels of input and may work in different ways, in which case it could provide a starting point for discussion.

It is not the first time that the area of fulfilling musical need after therapy has arisen. Wood (2006) outlined a matrix model for linking conventional music therapy sessions (individual / group music therapy) and non-conventional examples like workshops and concert trips. He based this on

> "an understanding that the essence of any form of music-making is the way in which music works within and between people. All formats of music-making can therefore become formats for music therapy, since all formats of music therapy are connected by this common operation of music" (Wood 2006).

Previously, Wood, Verney and Atkinson (2004: 49) spoke of how they:

> "[…] regretted the lack of opportunity for music therapy clients to pursue their new interest and ability in music once they had left their treatment institution. Often the outcome of music therapy is as much in musical and social skills as it is in a personal process. We considered it both arbitrary and wasteful for the beneficial effects of music to decline after a conventional course of music therapy".

There is also precedence in the very foundations of music therapy as outlined by Nordoff and Robbins (1977: 187-188):

> "The child has outgrown the need for, or scope of the particular kind of musical interactivity that individual therapy provides; occasionally he may use a musical situation which lends itself to individual creative expression. When appropriate, formal individual musical instruction can take over […]. Any personal dependence upon the therapists an individual child might still have diminishes under these conditions. He becomes an independently contributing member of a working group, sharing pleasure and interest with others and feeling pride in his own accomplishments".

These examples help give meaning and weight to the proposed music continuum model for working in schools. It is hoped it will also add to the argument for the presence of both music specialists and music therapists in special education settings.

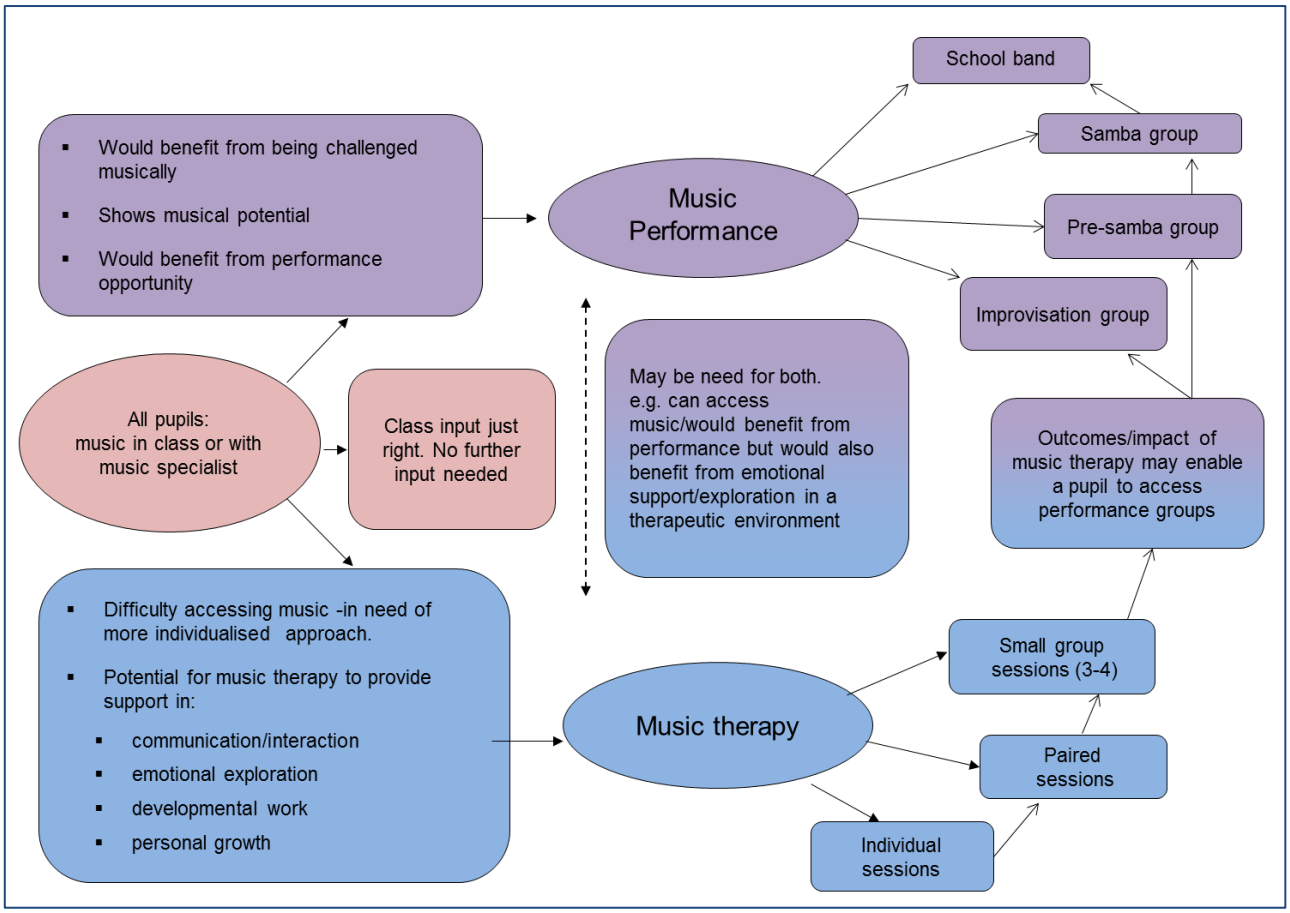

Figure 4: Model of continuum of music provision in the school

CONCLUSION

There are many benefits in rising to the challenge of providing evidence for funders in order to ensure continued funding of services. The evaluation project brought forth a wealth of information in relation to the aims of discovering the impact of music therapy on the pupils and the school, as well as ascertaining the quality of the service and if there were any improvements to be made. The findings demonstrated the highly positive impact that music therapy had on the pupils, both during sessions and outside of sessions. Music therapy was shown to have had a positive impact on the school as a whole, with staff having become aware of things like giving the pupil more time to respond, awareness of environment and use of voice which subsequently influenced their approach in other situations. The results also gave clear information that both parents and staff were satisfied with the quality of the service.

Subsequently the examination and exploration of music therapy's relevance to the funder's aims (with the aid of the evaluation and case studies) proved a worthwhile and valuable exercise. The process ultimately led to the formulation of a proposed model for a continuum of music therapy in the school. The discussion of where a music therapist's role lies when present alongside a music specialist can be illustrated via the continuum, giving significance to both roles. This vision of a music continuum has begun to materialise, with five pupils who have had music therapy input now attending one of the performance groups in the school (as at the end of the academic year 2013/14). By being able to access high-quality music making opportunities through music therapy and developing their potential in and through music, some pupils have had/will have the opportunity to take part in school music groups and potentially other groups in the future that are part of the youth music sector. For other pupils, music therapy remains the most appropriate way for them to access high-quality music making and to meet their needs. This all contributed to a case for the relevance of music therapy to the funder's aims. The funders continued contributing towards music therapy in the school and their commitment to the funding is currently confirmed up until the end of the academic year 2014/15. The school hopes to secure additional funding to continue exploring the potential of this music continuum of which music

therapy plays an integral part.

It is hoped that this paper can encourage other music therapists to embrace the calls to provide evidence to funders. In a simplistic yet important way, it helps us to ensure funding to undertake/continue the music therapy provision. However, it is also a process through which we may learn and develop our practice and gain clarity of our position and contribution. Let it inspire us to be creative, allowing the full potential of our music therapy services and of our clients to be achieved.

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APPENDIX 1: STAFF QUESTIONNAIRE

1. What has been your involvement with the music therapy service? *(Tick all applicable)*

☐ I attended the music therapy presentation on [date]
☐ I have accompanied a pupil to music therapy sessions
☐ I have observed a music therapy session
☐ I have been part of a music therapy group session
☐ I work in another context with a pupil who attends music therapy
☐ I have had a meeting with the music therapist
☐ Feedback from other staff
☐ Other *(please specify)*

2. In general, please rate the experience of music therapy for your pupil(s): *(Tick one)*

☐ Very positive
☐ Positive
☐ Neither positive or negative
☐ Negative
☐ Very negative
☐ Don't know / Not applicable

3. Have you noticed anything interesting, unexpected or different (positive or negative) about a pupil in relation to their music therapy experience? Tell us about it:

4. Please indicate how satisfied you are with the following: *(Please tick one for each row)*

	Very Satisfied	*Satisfied*	*Neutral*	*Dissatisfied*	*Very Dissatisfied*	*Not applicable*
a. Ease of communication between yourself and the therapist.	☐	☐	☐	☐	☐	☐
b. How the music therapy service fits within existing practical arrangements.	☐	☐	☐	☐	☐	☐
c. How the music therapist addresses the pupils' needs.	☐	☐	☐	☐	☐	☐
d. Information provided to you about the music therapy service.	☐	☐	☐	☐	☐	☐
e. Information sharing with the music therapist about the pupil(s)/therapy.	☐	☐	☐	☐	☐	☐

Any additional comments:

5. In your opinion what does music therapy provide, if anything, that is unique within the school?

6. **What improvements could be made to the music therapy service?**

7. **Have you learned anything from the music therapist that can be applied within your own work?** *(Tick one)*

☐ Yes
☐ No
☐ Not sure

Please give any examples:

8. **Any further comments?**

9. **What is your designation?** *(please tick all applicable)*

☐ Teacher
☐ Classroom assistant
☐ Specialist
☐ Member of management team
☐ I would prefer not to say
☐ Other (please specify)

Thank you very much for completing this questionnaire.
Your responses will help to ensure the quality of the music therapy service.
Your participation will remain anonymous.

Please return this questionnaire to reception by:
[date]

APPENDIX 2: PARENT QUESTIONNAIRE

1. Which of the following input does your child receive?

☐ My child attends individual music therapy sessions
☐ My child attends group music therapy sessions
☐ My child has attended both individual and group sessions at different times
☐ I'm not sure

2. Please rate the experience of music therapy for your child? *(Tick one)*

☐ Very positive
☐ Positive
☐ Neither Positive or Negative
☐ Negative
☐ Very negative
☐ Don't know/ Not applicable

3. How satisfied are you with the written reports about your child's music therapy?

☐ Very satisfied
☐ Satisfied
☐ Neutral
☐ Dissatisfied
☐ Very dissatisfied

4. Music therapy reports will be sent at Christmas and Summer. Is this frequent enough? *(Please tick one)*

☐ Yes
☐ No
☐ Not sure

Suggestions:

5. Did you meet the music therapist at parents evening on [date]?

☐ Yes *(go to a)*
☐ No *(go to b)*

a) If yes, how beneficial was this meeting?

☐ Very beneficial
☐ Of some benefit
☐ Neutral
☐ Not much benefit
☐ Of no benefit

b) If not would you like to meet the therapist at the next parents evening?

☐ Yes
☐ No
☐ Maybe

6. Do you have any suggestions for improving communication about your child's music therapy?

7. In your opinion, what does music therapy provide, if anything, that is unique for your child?

8. Would you like the music therapy service at this school to continue? *(Tick one)*

☐ Yes
☐ No
☐ Maybe

9. Any further comments?

Thank you very much for completing this questionnaire.
Your responses will help to ensure the quality of the music therapy service.
Your participation will remain anonymous.

Please return this questionnaire to reception by:
[date]

Suggested citation:

Cartwright, C. (2017). A voyage of discovery: From fulfilling funding criteria to revealing a clearer vision for music therapy in a special needs school. *Approaches: An Interdisciplinary Journal of Music Therapy, 9*(1), 80-98.

Article

The challenges of fostering and maintaining continuity in a music therapy group for mothers and children who meet primarily during school holidays

Okiko Ishihara

ABSTRACT

This paper explores the concept of *continuity* in the context of a long-term open music therapy group for mothers and children with learning disabilities between 5 and 18 years old. Based in a small rural village in Japan where there was no previous access to music therapy, the group has been active for 13 years and meets primarily during school holidays. Over time, up to 27 Japanese mothers with their children have participated in the group. The therapist encourages musical interaction and expression through musical improvisation and engagement with the family.

The significance of continuity in therapeutic practice is explored in different ways. In addition to focusing on a case study of individual music therapy with a child on the autistic spectrum (who attended the group), this paper presents feedback from the mothers who participated together with their children in the group. Theories and methods which the music therapist has found helpful in her work with the group are also discussed, such as the "back to basics" music therapy approach (Drake 2008) which draws on attachment theory (Bowlby 1988) and the writings of Winnicott (1960, 1963, 1971). Continuity is discussed in terms of helping the group to develop a safe environment to which the mothers and children repeatedly returned. It is proposed that the process of developing this safe environment, in turn, may eventually lead to the type of parent networking that may be able to support children with learning disabilities throughout their lifetime.

KEYWORDS

group music therapy; children and family; continuity

Okiko Ishihara qualified as a music therapist in 2001 at the Guildhall School of Music and Drama and completed an MA at Anglia Ruskin University, UK. Currently, Okiko works with children with learning disabilities in private practice and in communities, and with adults in mental health services in Japan. She also gives lectures at Soai University and Nara Medical University, Japan.

Email: Okikoishihara@gmail.com

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INTRODUCTION[1]

In Japan, young children (under 5 years old) with special needs and their parents are supported by services such as development centres. In April 2005 a law called *'The Act of Support for Persons with Developmental Disabilities'* took effect (Act No. 167 of 2004). By this act, understanding of and support for people with developmental disabilities became an obligation for society. As a result, development centres were built up in all prefectures and specific cities according to this law. In the education system, children (6 to 12 years old) who have developmental disabilities attend a special needs class either in a mainstream primary school or a special needs school. There is mandatory education until the age of 15. However, there are not enough specialists to support children with special needs in schools after 6 years of age. Only 52.7% of those between ages 6 and 15 in need of special education had access to support specialist teams (Cabinet Office, Government of Japan 2012).

In Japan, there is also the issue of consistency in continuing support for families with special needs children (Takahashi 2005). Nakashita et al. (2012) found that families with children with learning disabilities stressed a need for improved access to information and higher quality services. These same families thought it important that a greater understanding of special educational needs be encouraged. This was particularly true for nuclear families and families of children with autism between 6 and 14 years old.

It is also still a fact that children and families often drop out from existing services, and that support for children with special needs varies depending on the local authority (Tsujii 2014). Therefore, it is a reality that some mothers and children are isolated and that families sometimes decide to move to other areas where they can access better services.

THE PROJECT

The music therapy project started in 2001 in a small rural village with a group that parents themselves had built up for their children before a system of day care or development centres was put in place. The parents ran it by themselves, partly funded by the child welfare department of their local authority. They also made plans each year that included group trips or events. Such activities are sometimes a very important source of information about the care of children with special needs; they are also a very important potential source of contact between parents of such children.

The request for this music therapy group came from a mother in the community group expressing the need for quality experiences in children's lives and also the need to deal with feelings of fragility and isolation. Therefore, the suggestion for music therapy was based on the fact that music could provide a meaningful way of being together. Organisational issues for the implementation of the music therapy group involved identifying a location for the sessions, and arranging a suitable time schedule for both parents and children.

The music therapy group

Set up 13 years ago as part of a summer and spring holiday programme, this music therapy group now consists of 15 children between the ages of 5 and 18 and their parents. They live in the same local area, but each child goes to a special needs school or a special needs class in a mainstream primary school. The children have communication difficulties such as autistic spectrum disorder and learning difficulties such as Down's syndrome. Most of the time the mothers come with their children, but occasionally the fathers come instead.

The music therapy group takes place for five weeks during the summer holidays and three weeks during the spring holidays. The weekly sessions last for 30 minutes. Children and mothers who live in the same local area are welcome to join this group. A few people have joined this group as new members while some children have grown up and left, but there are 15 to 20 members who have had consistent participation in the group for 13 years.

The children can participate in this group until the age of 18. While this differs from shorter term therapy, such as a closed group over two years, when looking back over the whole process, the boundaries maintained by the therapist have clearly been important for the parents. A growing awareness of the value of boundaries has resulted in a secure framework. It may also have helped to maintain good relationships between therapist and parents.

The aim of *engagement with family* was initiated in the following stages:

[1] This paper is based on a poster presented at the first conference of the British Association for Music Therapy (BAMT), February 2014, Birmingham, UK.

Beginning the group

In the early stages of starting a group, the therapist assesses the needs of the participants while the participants slowly get to know one another. Initially, an individual or small group music therapy assessment session took place, tailored to individual children's needs and dependent on individual consultations with their mothers. After the first such session, and while watching a video recording of the session, parents and therapist reflected on the future aims for the larger music therapy group, and the possibilities and limitations of the proposed work.

Processing sessions

After each music therapy session, the parents and the therapist took time to talk for 15 to 20 minutes. During this time the parents and the therapist reflected on the session and discussed life events which had occurred during the week prior to each session.

Encouraging and maintaining confidentiality with respect to each child, between therapist and parents and between parents was important to the developing process. The parents and the therapist found time to talk with each other during the school term without their children being present. Video extracts of the work were presented to the parents as a whole group at the request of, and with permission from, the parents involved. The mothers shared feedback regarding other children, their own child, and/or their own feelings. In this way they received feedback and information from one another.

THEORETICAL INFLUENCES

At the start of the group in 2001, the therapist faced a challenge: how could she foster and maintain continuity for a music therapy group when the group could only meet all together during the school holidays?

School holidays grant freedom, rest and relaxation for children and mothers from the structures of the school term. Home and leisure times may come as a welcome relief from study and a rigorous timetable. However, in some cases, school holidays are not always 'positive'. For example, some children and mothers have difficulty enjoying leisure time or going out without special support. Some children may have feelings of anxiety, anger and depression upon being left in the world at large without the regularity or structure of the timetable of school and without external support (Salzberger-Witternberg 1983). The same may be true for mothers as well.

Music therapy is known to provide an appropriate opportunity to recreate the vital process of attuning to one another, for both children and parents, through sharing experiences of musical elements (Drake 2008; Oldfield 2006). This means that not only is the therapist 'tuning in' to the child, but also encouraging attunement between child and parent through musical interaction (Drake 2008; Oldfield & Bunce 2001). Watanabe et al. (1982) state that the feelings of mothers of special needs children can be similar to what Klein refers to as the loss of the good object resulting in mourning (Klein 1940). Mothers expect and hope an unborn baby will be healthy. In reality, if a mother knows that her child will have a disability and that she will have to live with this, she may need to find ways to accept her own difficult feelings. Since the process of exploring her feelings about her child's disability is similar to the process of the "loss of object" and mourning, a mother is likely to encounter within herself complex and difficult responses. Entering into music therapy may offer a way of working through emotions for these mothers and children.

At the beginning of the work, insecure parents are often surprised when they perceive their child's potential to communicate with a therapist in musical interaction (Drake 2008; Oldfield 2006, 2008; Oldfield & Bunce 2001). Working with parents alongside their children has shown to affect dynamics positively. These findings influenced the way in which the therapist worked with these Japanese mothers and children. When working with children, engagement with their family can be beneficial (Alvarez & Reid 1999; Grogan & Knak 2002; Oldfield 2006, 2008; Oldfield & Bunce 2001; Woodward 2004). This approach draws on the influence of Winnicott's writings.

Winnicott (1963: 77) writes of the mother's "continued presence" having a specific value for the infant, particularly if the instinctual life is to have freedom of expression. This concept informed the therapist's attitude with respect not only to the practical management of each session, but also in her thinking about how, without the therapist's presence, the group could be held during this long process. In other words, their understanding and sense of "continued presences" (Winnicott 1963) could also help children to prepare for separation from the therapist. Winnicott (1960: 47) also proposed that "continuity of being" is important for the development of the personality. He describes how the sense of continuous time in the infant

comes to be understood through the completion of the separation process.

Therefore, agreeing on the duration of therapy from the start, and keeping to the original timescale, is the most helpful way of providing a secure container (Grogan & Knak 2002). By building up a "secure base" (Bowlby 1988: 171) the quality of parting (at endings) and of reinstatement on the next meeting can be prepared for and worked through. Being aware of endings may also make clear the presence and absence of therapy. O'Shaughanessy (1964) points out that the absent object is a spur to the development of thought. It is possible to apply this concept to music. De Backer (1993) illustrates psychic acceptance of presence and absence in music. Therefore, these thoughts also supported this work. The musical framework itself can encourage confidence and engagement with another person through experience of musical interaction and expression in free improvisation.

CASE STUDY

In this section, the focus is on the description of a particular case of a boy within this project who has been attending the group for 13 years.

Vignette: An autistic boy, M

M, who has autistic spectrum disorder, was a six-year-old boy when the therapist first met him. In the beginning, he was tentative and was restlessly moving around. The therapist had individually worked with his mother, who was also tentative and showed lack of confidence. Although the therapist was not sure how well he understood this situation from his non-verbal behaviour, she explained the aims of music therapy to him and his mother.

First two weeks

M's ability to concentrate on music was very limited, and he freely moved around the room while laughing. The therapist was surprised by his restless moods. He was, however, sensitive. He could make some simple musical interaction vocally and through drum, tambourine and piano sounds. His rhythmic character was fragmented but he was interested in musical material using songs. Physically, he was resistant to contact with the therapist and made no eye contact but his voice, such as screaming, responded to her vocal improvisation. His mother calmly observed him from a corner of the room without any intimacy. Later, his mother and the therapist could talk composedly without him while other mothers looked after him in another room. When talking with the therapist, words of apology were repeated many times by the mother. She always seemed to have guilty feelings in regards to her son, which seemed to account for her tentativeness and perhaps his as well through her influence on her child.

One day, this mother had an opportunity to watch a video and see how her son behaved after the session. The therapist pointed out to the mother the therapist's sounds and helped her take note of how M felt fragile in this new situation. For M, music therapy focused on these aims: (1) increasing/prolonging the musical interaction, (2) offering opportunities for emotional expression by making the environment as safe as possible. By watching the video, the therapist confirmed the extent to which it was necessary to offer a framework to M.

After two weeks

M gradually showed some differences over time. He often sat down in front of a drum and cymbal and could maintain this position for a short time. He responded vocally with phrases such as "oya, oya" to the therapist's vocal improvisation. The therapist picked up his pitch, and he could also imitate the same pitch. He also prolonged the playing of a tambourine with stable beating. Sitting nearby him, the therapist was able to sing a short melody. He also showed interest in other instruments such as a xylophone but he could not find ways of communicating with the therapist through these. When this happened, he sought out physical attachment with his mother such as through piggybacking or holding on to her. She was sometimes embarrassed by his sudden strong jumping.

During parents' group

M's mother was normally very calm in the group and rarely talked about her own feelings. Other mothers' words were often supportive and friendly when addressing her. She was well-accepted by the group and she warmly listened to the other mothers' worries.

After eight months

The spring following his first summer in the group, M showed difficulties and instability by trying to leave the room. He positively came beside the therapist, saying "drum", but he soon left the room.

His mother tried to stop him, and then she initiated the making of sound, saying, “Let’s play a drum”. M repeatedly came back to play a drum and then left the room. In her feedback at the time, M’s mother said that he sometimes showed rebellious phases and that she had difficulties dealing with him, but she spoke more positively about her feelings saying that she did not feel as bad as she had done. We thought that any difficulties might be due to his unstable feelings in these situations and she understood that this was likely the case.

For a short while, he continued to occasionally try to get out of the room. The therapist continued to give him musical structure, such as hello and goodbye songs at the beginning and ending of sessions. In particular, he usually came beside her towards the end of the session and certainly seemed to understand the session would end soon.

Outside the sessions

Other mothers talked in a friendly way with M’s mother and M. M’s brother and father occasionally appeared to support M’s mother while M waited in another room.

After one year

One year after commencing music therapy, M showed signs of development, such as playing with a drum and the piano while sitting beside the therapist. His responses to the therapist’s sounds became more musical through the use of instruments. His mother held his instruments, such as a tambourine, or made simple sounds, staying beside him. These were more enjoyable moods. He also interacted vocally while rocking his chair. The therapist improvised using her voice and held a repeating musical form by playing the piano, tuning into his rocking beats. His mood had changed and become more relaxed. He smiled and made eye contact with the therapist. When M smiled at her or his mother, the therapist noticed his mother’s smile.

During parents’ group

After three years, M’s mother had to take her turn as the group leader of the group and liaise with the administrative services for making plans and preparations, including but not limited to reserving work spaces, and collecting and submitting documents in order to secure funding. She devoted herself to these responsibilities and came closer to other group members. At the same time, she showed confidence when she spoke out more to others in the group. Gradually, her participation made her a more experienced member by developing her skills as a good listener and adviser for other mothers who had children younger than M.

After six years

M came to enjoy playing instruments more than he had in the beginning. He was mostly interested in playing a snare drum. He often explored its various sounds, such as those of the snare wire, frame, skin head or sticks. He also preferred to play his drum with my playing of a conga or a djembe drum. On the other hand, M still occasionally came into the room while tightly holding his mother’s arm. Such being the case, he would come wearing the hood of his parka up with his head down. M’s mother always talked to him calmly, telling him that music therapy’s time had started. M mostly sat in front of the drum by himself. Even though he did not make any sounds, he glanced and smiled bashfully at the music therapist while listening to her playing the piano.

After 12 years: Towards the end of the sessions

M continued consistently coming to music therapy for 12 years. He turned 18 years old and was taller and bigger than his mother. Over the past few years, he had happily entered the room without his mother and started smoothly playing a drum. In the summer of 2013, the therapist responded to his improvisation with sticks by playing a conga. He often gazed at the therapist with a big smile and became somewhat shy when their music became more interactive. Near the end, his stable beats seemed to become more prolonged than usual as if in acknowledgement of the approaching ending of the session. When the therapist started playing a familiar goodbye song, he made eye contact many times, and he calmly gave her the pair of sticks. He had come to understand the end phrase. The therapist confirmed that the sessions would end next spring.

After this session’s ending, M’s mother smiled warmly at him. He bowed to the therapist, after saying words such as “goodbye”. His mother laughed, saying “Did you enjoy yourself?”. He laughed and nodded, saying “ah, ah”. During feedback time with his mother, her attention was turned toward his future after graduation. Her speech seemed to show more confidence and

feelings of fulfilment regarding his growth, rather than expressing anxiety.

EVALUATION

The evaluation context

Over 13 years, 27 families participated in the community. However, due to children growing up and graduating, then being replaced by younger children, at any given time there were 15 families involved in the evaluation of this work. The evaluation was carried out mainly for the purposes of music therapy practice evaluation, rather than researching the effectiveness of the work. The aim was to define: (1) mothers' and children's needs in relation to the music therapy group; (2) any possible benefits that mothers and children may have experienced from taking part in the music therapy group; (3) whether or not the parents felt that the music therapy group was addressing their needs. Therefore, when this project passed the 11-year mark, a questionnaire (Table 1) was given to all of the parent members of the group to fill in and return to the music therapist.

Ethical considerations

The evaluation methods were based on Ethical Guidelines for Research 2005 (Japan) and the Data Protection Act of 1998 (UK). All interviewees were given a verbal explanation regarding their participation. An information sheet on the study including information on protection of anonymity, confidentiality, and privacy was distributed to all participants. The information sheet and consent form was signed by all interviewees. Data prepared for publication excludes specific information (i.e. local area, name). The sessions, however, had been recorded, based on a consent form for participation signed by parents. Regarding the case study and the interview of the mother in this particular case, in addition to the above procedure, permission for photos and the presentation of the case was requested and the mother signed the necessary form, which also stipulated that subjects would remain anonymous.

Data collection and questions

Parents were given a verbal explanation to complete a semi-structured feedback questionnaire anonymously. The questions were both closed and open (see example 1: Questionnaire). In addition, an interview was conducted with M's mother in order to determine: (1) her feelings at the beginning of the music therapy programme, (2) the reasons for continuing, (3) any changes in her feelings since the beginning of the music therapy programme, (4) her feelings after the end. All completed sheets were collected for evaluation by the therapist.

1. Have you experienced any benefits from coming to this group for children and mothers? If so, what are the benefits?
2. Do you feel any benefits from coming to the music therapy group? If so, what are the benefits?
3. Do you feel it's appropriate to have music therapy group sessions during holidays? Why do you think so? If not, when would be appropriate? (e.g. when, frequency, and so on)
4. Do you have any other comments about this music therapy group?

Table 1: Questions includes in the questionnaire

Data analysis

The first set of qualitative data was collected and analysed using the thematic analysis method, which consisted of stages of coding, categorising, and identifying themes (Ansdell & Pavlicevic 2001; Tsiris, Pavlicevic & Farrant 2014). The qualitative data with coding provide the themes illustrated in the table below.

FINDINGS

Mothers' views

The answers of the closed questionnaire for Q. 1-3 were 100% positive. Only for Q. 4 regarding the appropriate time for sessions did one parent answer with a negative response. The reason for the response was that she wanted to increase the benefits, as her child had benefited from these sessions. Her request was to meet once a month, not only during spring and summer holidays. These results indicate the benefits of this work.

The qualitative data from the open-ended questions were identified using the thematic analysis method (see Table 2). From the data, these themes emerged: i) relation to others; ii) the value of being a member of a long-term group; iii) holding environment. Descriptors under the two codes 'group feedback' and 'music therapy' show there were benefits from both the group feedback and the music therapy sessions. Common codes

were found such as 'experiences together' and 'experiences of communication' with others through music in both contexts, meaning there is correspondence between the group and music therapy work.

Theme I: Relation to others

This theme includes the categories 'experiences with others', 'expression of feelings', and 'co-operation in a group'. Linking the theoretical thinking of 'object relation' (Klein 1940), experiences in relatedness to others are important. The need for, and benefits of, sharing experiences with others and being able to express feelings to others are clearly felt by parents of disabled children as well as the children themselves. This implies that the group, or the workings of this music therapy group, can provide continuity between the inner concerns of the parents and children and the external world. The group may serve the function of "a potential space" (Winnicott 1971: 41).

Theme II: The value of being a member of a long term group

This theme is evident in three categories: 'seeing the development of children in relation to mothers' self-confidence', 'need for and benefits of long-term support', and 'hope for continuity'. Firstly, many parents felt the benefits by seeing the development of their own and other children in a long-term frame. This also led to greater self-confidence on the part of the mothers. All of this may indicate the importance of being members in a group for a long-term period for all involved members, such as the therapist, the parents and the children. Secondly, all parents indicated the need for some support. They characterised the intervention of a therapist or specialists in the group as a benefit. This corresponds to the results of Nakashita et al. (2012) indicating a need for continuity of specialists' support. Bunt and Hoskyns (2002: 36) state that at the most fundamental level, the therapist needs simplification to "be with" the person needing therapy, which is also related to the theme of presence of being. Finally, members of the group hope that this group and the music therapy work will continue. It is a fact that planning, preparations and securing necessary funds for running this project require much effort from parents every year.

Theme III: Holding environment

This is the theme which returns to Winnicott's idea of "the holding environment". It also indicates that an important factor in therapy is helping the work in a group. The code, 'feeling comfortable in a group', and category, 'offering a safe environment', are included. This is the comfort that comes from a holding environment, which also links to Bowlby's "secure base" in therapy.

One of the mothers said that:

> ''This group always makes me feel like I am back home. My son also seems to feel that way. I feel comfortable in the group. Everyone who has attended over the years has created a bond in this group. Everyone has come to know my son and me over the years. I do not feel that anywhere else."

This shows that this small group has provided a safe, comforting environment to this child and his mother.

Codes		Categories	Themes
Group	**Music therapy**		
❑ experiences together	❑ experiences of communication with others through music	❑ experiences with others	❑ relation to others
	❑ experiences of concern for others		
❑ learning from experienced mothers	❑ learning/experiences of new things		
	❑ enjoy expressing their own feelings	❑ expression of feelings	
	❑ enjoy feeling something through music		
❑ many eyes could look after children	❑ co-operation with others	❑ co-operation in a group	
❑ being happy to see children have been enjoying a full life	❑ felt development of child in the music group	❑ seeing development of children and relation to mothers' self-confidence	❑ the value of being a member of a long-term group
❑ could be more confident about the future after seeing older child	❑ could see other children's development		
	❑ could notice the ability of child		
❑ can feel less isolated	❑ can talk with a specialist	❑ need for and benefits of support long-term	
❑ can communicate with other parents	❑ the therapist has followed children's development long-term		
❑ hope the group continues running	❑ hope the music therapy group continues running	❑ hope for continuity	
❑ can share many feelings	❑ feel comfortable	❑ offering a safe environment	❑ holding environment
❑ feel comfortable			
❑ has created a bond in this group			
❑ get various points of view and information			
❑ need somebody's support during the holiday			
❑ feel difficulties doing everything by themselves during holidays			

Table 2: Findings arising from the thematic analysis

Analysis of the individual interview with M's mother

A summary of findings is reported below on how music therapy has affected M's mother and, conversely, how her feelings have helped her son and this work.

As previously discussed, parents with special needs children may experience a process of mourning that takes time to overcome. Watanabe et al. (1982: 242) referred to this as a "chronic sorrow" which may affect the parents of a special needs child for a long time and may not be easy to absorb or deal with.

At the beginning

Codes: How to communicate; Difficulties; Hopelessness

M's mother said:

> "I did not understand how I should communicate with him. At that time, I did not have any hope at all that he would develop and his difficulties would be reduced."

She sometimes showed mourning feelings such as guilt in the sessions (#1), which may simply be a part of various feelings in the early stages of therapy. Difficulties surrounding M's communication ability and how to communicate with him may have created feelings such as cutting off continuity of hope for all participants.

The reason of continuing:

Codes: Love music; Mother's self feelings; Easily continuing; Help

> "He loved music; however, he sometimes tried to leave the session room. As I thought that he would get used to music therapy, I was never absent from any sessions. Maybe, I also may have had too much pride and obstinacy for myself. Another reason why I could easily continue to participate in these sessions was the cheaper cost, because the local authority helped me with the payments."

M's mother now knows that he loves music. She recognised evidence of his love of music in sessions, even though he tried to get out of the room. This factor led to the continuation of this work. She also acknowledged her own feelings of pride and obstinacy, which stem from her self-regard on the one hand and outside pressure on the other. The ability to easily take part in music therapy helped to continue. This may have partially removed much of the pressure. In this case, economic support was doubtlessly an additional form of help.

About changed feelings after finishing a music therapy

Codes: To realise child's potential; Continuing without pressure; Mother and child both becoming stronger

> "I realised the fact that he could concentrate on doing music... I believe that continuing with this work will develop over time without any pressures, and we might become stronger."

A code, to realise a child's potential, leads to the same categories in Table 2, which is seeing development of children in relation to mothers' self-confidence. Seeing the children's development affected the process positively and may have helped mothers recover from the process of mourning. It was also clear that continuing without pressure helped them. Watanabe et al. (1982) said that overcoming emotional experiences of parents' selves will grow the capacity for adaptation to face other problems. "Being stronger", M's mother's expression, will build this capacity towards autonomy.

After the ending

Codes: Gratitude; Experienced mothers; Foresight; Valuable experiences beyond music group

> "Thanks to the experienced mothers who had foresight, both my child and I enjoyed our time here over the years... He was able to experience not only music but also other things beyond it. I feel many thanks for this group."

The completion of a process typically finds a person reflecting back on that process. This engages feelings of confidence and fulfilment such as those shown at the ending session ('*Towards the ending session*') and leads to gratitude for all experiences and relation to others. In the above statement, one finding is that "foresight" is an important point to help parents have hope for the future. The core of music therapy work may also affect other valuable experiences in a group.

Other comments

Codes: Confined self with child; Hope; Benefit

> "When this music therapy was just starting, I did not have any support. I confined myself with my child in our home during holidays... The times became better than before. I hope many people have a chance to benefit from this and have the opportunities to experience it."

M's mother's view has changed as an experienced mother to one who has gained perspective on the entire (and long) process. In other words, an experienced mother has overcome emotional experiences with her own child. Her hope connects with a hope that her positive experience will spread to many other people, and to hope for the future.

DISCUSSION

There were three aims for the evaluation: (1) what the children and mothers need from the music therapy group; 2) any benefits that the mothers and the children may derive from belonging to the music therapy group; (3) whether or not the music therapy group was addressing their needs.

1) What the children and mothers need from the music therapy group

Three themes arose from the interviews with the mothers: 'relationships with others', 'the value of being a member of a long-term group', and 'the holding environment'. All three themes connect to the children's and mothers' needs. The themes also closely match the core theoretical concepts previously outlined (Drake 2008; Oldfield 2006). Examples included stimulating the vital process of attuning to one another in the group work and the individual work the therapist undertook with M. In the work with M, simple vocal interaction and attuning simple musical elements helped the music therapy process between M and the music therapist, particularly at the beginning of the work.

In addition, there was the value of having a long-term group in which not only the mothers, but a specialist music therapist together with the mothers, was engaged in trying to understand the children's development. Their needs were being supported by this well-contained and supported environment.

2) Any benefit that the mothers and the children may derive from belonging to the music therapy group

By belonging to a music therapy group, mothers and children could experience relating to others. A music therapy group itself may give them as well as the music therapist a sense of long-term presence. This is also a benefit of music therapy. Belonging to a music therapy group can offer them the holding environment and the secure base relationship in a group.

3) Whether or not the music therapy group was addressing their needs

The positive answers of the closed questionnaire may indicate their needs were addressed; one person, however, requested meetings once a month, not only during holidays. This request for more meetings might indicate a need for more support, not only benefits. In addition, the case study may indicate that the music therapy group also helped the development of M and his mother.
Factors considered mainly helpful to foster and maintain music therapy meeting primarily during school holidays might include: (1) the core of musical work in facilitating interaction made a "secure base" (Bowlby 1988: 171) in therapy; (2) continuity supports made a bonding-relationship and secure environment in a group; (3) repetitive stable musical space created and formed a frame of time and space in holidays; (4) "mother's continued presence" (Winnicott 1963: 77) supports children during the space of absence of therapy.

Based on the parents' reviews by distributed questionnaires and the case study of M and his mother, mothers also experienced their children developing and realised more about their potential through the music therapy process. One example showed M's mother recognised her son's love of music in sessions. Music therapy may have offered her opportunities to recognise that music can help "the vital process of attuning to one another" (Drake 2008: 41). "Mother's continued presence" (Winnicott 1963), such as the case of M's mother, had value and supported M during the space of absence of the therapist and therapy. In other words, during the absence of therapy, the sense of "mother's continued presence" is an important factor. In this case, mothers confirmed the value of playful work through music for their children's development. Mothers recognised how important it

is to tune into their children using musical elements, giving mothers a way of attuning to their children. The music therapy sessions in holidays may also have given a space for confirming the mothers' presence. If the mothers and children are contained in a stable continuity and framed space and time, mothers can make use of the music therapy in holidays, despite meeting only intermittently during holidays. These pieces of holidays are contained and connected time to time by stable repetition. Music therapy may have created the value in space and time in holidays for mothers and children. In addition, witnessing child development and having experiences in relation to others in this work might be one helpful way to support a parent during the long mourning process of one with a special needs child. In this case, the therapist has made a relationship of trust with each child and mother in this process, and at the same time, reflection on the work completed up to now shows trustworthy relationships made between each mother and child, which may lead to a healthy interdependence of the group from the therapist and of members themselves in the group.

The therapist encountered some limitations in working this way. With severely insecure children (or indeed mothers), it may be difficult to work through deep feelings in such a short span as school holidays. The therapist needs also to be open to make further recommendations or referrals for more regular therapy or other specialists. For a music therapist, there are challenges in balancing the reality of the community context and tuning into clients' needs. Procter (2001) suggests the work needs to be flexible, and geared to balancing the needs of individuals in non-medical settings.

Evaluating the work with this group did not arise as a specific research project, rather as a way of evaluating the therapist's own practice. Prior to the interviews with the mothers, the therapy was being evaluated in the normal way by the therapist writing session notes. In thinking about this evaluation process, there is a recognition that gathering qualitative data after 11 years gives a limited view. However this data has provided the therapist with information to be able to make use of in terms of her developing work with this group. The mothers themselves expressed hope that the music therapy group will continue to run in the future. The evaluation has therefore contributed to plans for future work with the group.

CONCLUSION

The challenges of a music therapy group for mothers and children who met primarily during school holidays were around how to encourage musical interaction and expression using music improvisation and engagement with the family. This work was evaluated according to the following aims: (1) what the children and mothers need from the music therapy group; (2) any benefits that the mothers and the children may derive from belonging to the music therapy group; (3) whether or not the music therapy group was addressing their needs. By analysing the qualitative data of mothers' interviews, three themes emerged: i) relating to others; ii) the value of being a member of a long-term group; iii) the continuity of the holding environment. These themes share links with the "back to basics" music therapy approach (Drake 2008), which draws on attachment theory (Bowlby 1988) and the writings of Winnicott (1960, 1963, 1971). The positive responses of parents, gathered from a returned questionnaire indicate that the parents' needs were being addressed by participation in group music therapy sessions. A particular case study and a mother's view illustrated that continuity of music therapy affected the development process of an individual child and a mother. The limitations of the evaluation work, however, gave the therapist space to consider the need for further study to address the group's future development.

Stable continuity became a core part of the way in which this group has developed within a safe environment. The group has become a holding environment for both mothers and children. The dynamics in this community appear to have become more cohesive, positively influencing this work. Reflecting on Winnicott's words, the potential of community itself may encourage a sense of "continuity of being".

Ultimately, fostering and maintaining continuity within a music therapy group that meets primarily during school holidays was a challenge for the therapist. She attempted to fine tune the holding environment by taking into consideration, and working within, the practical limitations of the group's availability. Exploring the significance of continuity in a music therapy process may enhance the efficacy of music therapy for children and mothers. Continuity is also central to providing consistent, continuous and realistic support for children with special needs and their families in Japanese society.

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Article

Music therapy as a profession in Spain: Past, present and future

Melissa Mercadal-Brotons, Patricia L. Sabbatella & María Teresa Del Moral Marcos

ABSTRACT

The use of music for therapeutic purposes has a long history in Spain. For many years, clinical practice, training and research related to music therapy have been present in the country. Several people from different areas of the country have acted as pioneers, contributing great effort and dedication to the establishment of this profession. However, perhaps because these pioneering efforts lacked unity or failed to follow similar directions, there is still a long way to go before this discipline and profession become consolidated and integrated within the education and health systems, and recognised by the relevant authorities. To advance along this way, it is important and necessary to analyse where the music therapy profession lies at present in order to identify those aspects which hinder its development and consolidation.

KEYWORDS

music therapy in Spain; professionalisation of music therapy; music therapy accreditation (music therapy register); music therapy development

Melissa Mercadal-Brotons, PhD, MT-BC, MTAE. Music therapist specialised in the area of gerontology and dementias. Member of the Research Group PSICOPERSONA (FPCCE-Blanquerna, URL). Director of the Master Programme in Music Therapy (idEC-UPF, Barcelona). Coordinator of Research and Master Programmes (Escola Superior de Música de Catalunya-ESMUC). EMTC Spanish Delegate. Chair of the Publications Commission (WFMT).

Email: melissa.mercadal@esmuc.cat

Patricia L. Sabbatella, PhD, EMTR-Supervisor, MTAE. Senior Lecturer at the University of Cadiz. Director of the Postgraduate Music Therapy Programme. Educator, researcher and clinician in the field of music therapy and music education with special interest in inclusive music education and special education; musical development and music therapy assessment, and music therapy and mental health. Lead researcher of the Research Group HUM-794: Music & Movement in Education and Therapy (Andalusian Research Programme). She has served on professional boards of the World Federation of Music Therapy (WFMT) and the European Music Therapy Confederation (EMTC).

Email: laboratorio.musicoterapia@uca.es

María Teresa Del Moral Marcos, PhD student, MTAE, music therapist (Escuela de Música y Danza 'Santa Cecilia'), lecturer and coordinator of Music Therapy Master Programme (Universidad Pontificia de Salamanca). Vice-President of Asociación Española de Musicoterapeutas Profesionales (AEMP).

Email: mtmoralma@upsa.es

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HISTORY AND BACKGROUND

The first references to the therapeutic use of music in Spain date back to the 18th Century. In the 19th century some dissertations (Poch 1999) addressed the relationship between music and medicine, and in 1920 Dr Candela Ardid published the book *'The Music as a Curative Medium of the Nervous Diseases: Some Considerations about Music Therapy'*. In the early 1960s, music therapy as a profession was introduced by Dr Serafina Poch. Since then, many initiatives and projects have developed in public and private institutions (Poch 1993).

In 1975, the first Introductory Music Therapy course was taught by Rolando Benenzon in Madrid. The Spanish section of the International Society for Music Education (ISME-Spain) established a study group dedicated to music therapy. In 1977, the *Spanish Association of Music Therapy* (*Asociación Española de Musicoterapia*) was founded by Dr. Serafina Poch and colleagues. In 1983, she established the Catalan Association of Music Therapy (*Asociación Catalana de Musicoterapia*) in Barcelona. In the same year, in Vitoria-Gasteiz (Basque Country), Aitor Loroño and Patxi del Campo founded the Centre for Music Therapy Research (*Centro de Investigación en Musicoterapia*). During the 1990s, particularly after the VII World Congress of Music Therapy, which was celebrated in Vitoria in 1993, interest in music therapy began to increase both as a discipline and a profession. In the late 1990s, Spanish health-allied professionals began to show significant interest in music therapy. Several more music therapy associations were also founded at this time and at the beginning of the 21st century (Sabbatella 2004).

Today, music therapy is applied in education, medical and community settings. Music therapy training is offered at different universities and private institutions, and research activity is carried out with a corresponding increase in the number of publications. However, Spain still faces the future with challenges such as professionalisation, the unified vision of the professional role, and the official recognition of the field by the national government (Mercadal-Brotons & Sabbatella 2014).

TRAINING AND EDUCATION IN MUSIC THERAPY

Music therapy training programmes – at Master's or postgraduate level – are offered both by private institutions and universities. In 1986 the first training courses in music therapy were offered by private institutions [School of Music Therapy and Group Techniques, today known as *Asociación Música, Arte y Proceso* in Vitoria-Gasteiz, and *Centro de Investigación Musicoterapeútica* (Music Therapy Research Centre) in Bilbao].

During the 1990s, interest in music therapy training grew and music therapy seminars, workshops and training programmes sprang up in different universities. In 1992, the first university music therapy programme was offered at the University of Barcelona, with Dr Serafina Poch as the Director.

In 2014, the university status of music therapy in Spain was:

- Postgraduate music therapy training programmes offered by public or private universities. There are no music therapy departments or faculties, so studies are linked with related scientific areas such as music, psychology or medicine. Results of a study conducted by Poch (2013) show that by 2012 a total of 1,844 students had qualified as music therapists through university training in Spain. Sabbatella (2005) conducted a study about the status of music therapy at Spanish universities concluding that there was a notable variety with regard to the structure of music therapy training courses offered by universities in Spain. The university courses showed differences in structure, academic level and theoretical orientation of training. No unified criteria were identified that defined the core areas of study, subjects, skills or competences required to become a professionally qualified music therapist, although there were common objectives and areas of study. Since 2010, and according to the European Higher Education Area (EHEA), all music therapy training programmes are required to adapt to the European Credit Transfer System (ECTS). As yet, there are no specific PhD programmes in music therapy in Spanish universities.
- Music therapy optional/elective subjects offered within official undergraduate/Bachelor degrees (e.g. psychology, education, nursing).
- Introductory courses, summer courses, seminars and workshops. The aim of this type of course, offered by public or private institutions, universities and associations, is to promote and introduce music therapy among health-allied professionals, potential students, and the general public. These types of training do not lead to any qualification.

CLINICAL PRACTICE IN MUSIC THERAPY

Different studies regarding the professional profile and status of music therapy in Spain show that music therapy clinical practice is active and music therapists work with a wide variety of populations, from children to adults in education, community and health areas. However, most professionals seem to work on a part-time basis and on specific projects as opposed to holding full-time jobs (Sabbatella & Mercadal-Brotons 2014).

Ortiz Ruiz and Sabbatella (2011) conducted a research study based on a survey design to describe the professional profile of music therapy in Spain, including demographic information, education, working style, assessment and intervention methods of music therapists in clinical practice. The respondents (n=57) showed an overwhelming predominance of women over men (76.27% vs. 23.73%), with an average age of 41.1 years, and with professional experience of 8.3 years. According to the results, Madrid (35%), Catalonia (17%), Andalusia (17%), and Valencia (10%) appeared to be the regions with the majority of active professionals (79%). Children (27.11%) are the most served followed by adults (25.42%) and elderly people (11.86%). These results are very similar to a later study conducted by Sabbatella and Mercadal-Brotons (2012). This study showed that the majority of music therapy professionals in Spain hold a Master's degree (73%), work part-time (43%) or on specific projects (40%) and mainly in private institutions (48%). The populations most served are intellectual and developmental disabilities (16%) followed by mood disorders such as depression (12%) and Autism Spectrum Disorders (9%). The salaries of music therapists seem to be comparable to those of a psychologist (30%) or a teacher (26%). Practising music therapists in Spain are members of a national or a regional professional association (70%).

Mercadal-Brotons (2011) conducted a survey with the objective of presenting an overview of the music therapy scene in Spain in the area of gerontology with regard to: (a) populations most served by music therapists, (b) characteristics of the institutions, (c) training of the professionals who implement music therapy programmes, (d) working conditions, and (e) types of programmes implemented. Although the number of respondents was small (n=20), results showed that 75% of the survey participants working in gerontology are women. The mean number of years in the field is 6 (SD=7) and the population of dementias is the most served in geriatric settings (45%) followed by other neurodegenerative conditions (15%). The results of this study also indicate that the majority of music therapists working in gerontology who responded to the survey work in private institutions (55%) and on a part-time basis (90%).

These three studies show similar results with regard to dominant gender of the music therapy profession in Spain, number of years of the practitioners in the field, the working arrangement (part-time vs. full-time) and the type of institutions (private vs. public).

MUSIC THERAPY MODELS AND PHILOSOPHICAL ORIENTATIONS

Sabbatella (2004) suggests that the different approaches and theoretical orientations of music therapy clinical practice in Spain are influenced by several issues:

- Cultural: music therapists in Spain come from different schools of training, different countries and some of them hold degrees from foreign universities.
- Academic: Theoretical orientation in clinical practice is related to the music therapy training and orientation of the teaching staff.
- Professional: Spanish music therapists choose their professional theoretical orientation according to their area of work (education, psychotherapy, medicine).
- Geographic: Music therapy projects are developed in cities that are separated by long distances. This situation does not facilitate professional exchange or contact.

In the last decade, some research studies have been conducted to identify the models and philosophical orientations of Spanish music therapists. At the beginning of the decade, Sabbatella (2003) found that music therapists seem to adopt an eclectic approach based on a variety of active methods and on the principles of the Benenzon music therapy model. The techniques most frequently used were improvisation with percussion instruments, listening to music and movement with music. The respondents stated that assessment of clients followed an informal procedure as opposed to standardised assessment tools. Areas of assessment and evaluation of clients included musical and non-musical behaviours. Descriptive methods were used to report assessment results. The number of

respondents was low (n=13), but relevant regarding the estimated number of practising therapists in Spain in early 2000.

In a later study (Ortiz Ruiz & Sabbatella 2011) with 57 respondents, the theoretical orientation of music therapists showed more variation: humanistic approach (30.61%), behavioural (22.45%), psychodynamic (20.41%), eclectic (14.29%), Gestalt (10.20%) and systemic (2.04%). Music therapy models included Nordoff-Robbins (20.73%), Benenzon (19.51%), behavioral and analytical models (8.54%) and the Bonny method of Guided Imagery and Music (GIM) (3.66%). These results were congruent with the evolution of the profession in Spain and the development of the theoretical basis of music therapy clinical practice worldwide.

The most recent study undertaken regarding the status of music therapy in Spain, conducted by Sabbatella and Mercadal-Brotons (2014), identifies theoretical approaches and methods used by 122 music therapists. Theoretical approaches covered a broad perspective and are similar to those highlighted by Ortiz Ruiz and Sabbatella (2011).

With regard to music therapy methods used in clinical practice, Sabbatella and Mercadal-Brotons (2014) found that the most frequent method used in clinical practice is improvisation, including free improvisation techniques (72.1%), free improvisation with voice (47.5%) and free improvisation with voice and instruments (50%). Composition methods used include song composition (20.5%), instrumental composition (17.2%) and instrumental and song composition (15.6%). Listening methods are used by 50.8% of the respondents; techniques used include listening with verbal expression (27%), sound-music visualisation (19.7%), guided music listening (17.2%) and listening with graphic expression (10.7%). Dramatic techniques used include body-movement techniques applied to music (41%), music drama (31%) and improvisation-drama-movement combination (23.8%). Eclectic techniques used include playing musical instruments (59.8%), music games (52.2%), therapeutic singing (28.7%), sonification of situations (23.8%) and recording sound sequences (22.1%).

RESEARCH IN MUSIC THERAPY

Del Moral, Sánchez-Prada, Iglesias and Mateos-Hernández (2014) conducted a descriptive study about the status of music therapy research in Spain concluding that music therapy scientific publications have appeared regularly since 1985. Furthermore, this study showed a progressive increase in music therapy scientific publications in the country. An update of the previous study (Del Moral, Mercadal-Brotons & Sánchez-Prada 2014) has identified 479 music therapy publications[1], between 1985 and 2013, with the participation of Spanish authors and/or co-authors. These included articles (38 %), books (15 %), chapters (4 %), papers (41 %) and theses (2%). Higher numbers of publications were found in the years 1993, 2006**,** 2008, 2010 and 2012, coinciding with the celebration of national and international congresses (Del Moral, Mercadal-Brotons, Sánchez-Prada, Mateos-Hernández, Hernández-Crego & García-Martín 2013). Regarding dissertations, a total of 13 were found in the Spanish Dissertations database 'TESEO' (2014) which included the term music therapy in the title. The topics addressed in doctoral dissertations written by music therapists are: music therapy interventions (10), music therapy methods of evaluation (1) and history of music therapy (1). Music therapy dissertations have been conducted by music therapists and non-music therapists, within doctoral programmes of related fields and most of them were not supervised by music therapists.

[1] These music therapy publications were found in the following databases: Scopus, Proquest Research Library, Web of Knowledge (now Web of Science), Science Direct, Ebsco, Academic Search Premier, E-Journals, PsycInfo, Medline, PubMed, Eric, Cairss, Rilm, Dialnet, Teseo, Proquest Dissertations & Theses; and book catalogues: Catálogo de la Biblioteca Nacional de España (BNE – Catalogue of the National Library of Spain) and Red Española de Bibliotecas Universitarias (REBIUN – Spanish Network of University Libraries). National and international music therapy congress proceedings and national and international music therapy journals were also reviewed.

MUSIC THERAPY AS A PROFESSION: STEPS TAKEN TOWARDS THE ORGANISATION OF THE PROFESSION

Currently in Spain there are a total of 48 music therapy associations listed in the National Associations Register of the Spanish Ministry for Home Affairs (Ministerio del Interior 2014); one is a recently created music therapy federation (*Federación Española de Asociaciones de Musicoterapia*) (July 2014). Ten of these associations are members of the EMTC (http://emtc-eu.com/member-associations/)[2] and these EMTC member associations choose the country's representative every three years. The large number of associations prevents a unified vision of the profession in professional and academic fields, and does not allow the profession to be taken seriously by members of other health-allied professions and competent authorities.

Among the 48 music therapy associations, two categories can be identified according to their purpose, objectives, and level of national recognition. One of these categories comprises professional associations that are non-profit music therapy associations created at national or regional level, seeking to further the development and social inclusion of the music therapy profession and the interests of practising music therapists. The Spanish music therapy associations which have members of the EMTC are within this category. Furthermore, we wish to emphasise the Spanish Association of Professional Music Therapists (*Asociación Española de Musicoterapeutas Profesionales* – AEMP) which was approved in September 2007 by the Spanish Ministry of Employment and Social Security (*Ministerio de Empleo y Seguridad Social*). The AEMP represents a landmark towards the professionalisation of music therapy in our country, and because of its registration in the Spanish Ministry of Employment and Social Security, this association has the potential to become a union when the profession is fully recognised. Its main objective is the regulation of the profession of music therapy in Spain (Mateos-Hernández & Fonseca 2008).

The second category includes groups of music therapists who come to an agreement to create an organisation for job-related activities and to benefit from the fiscal advantages this type of organisation offers.

The field of sociology has used several criteria to define professional status. Saks (2012) points out that most lists of criteria include a high level of knowledge and expertise or related items as special features – alongside other characteristics such as codes of ethics, altruism, rationality and educational credentials. Moreover, Perks (1993) states that the main achievements that may identify the professionalisation of an occupation include: (1) an occupation becoming full-time, (2) the establishment of a training school, (3) the establishment of a university school, (4) the establishment of a local association, (5) the establishment of a national association, (6) the introduction of codes of professional ethics, and (7) the establishment of state licensing laws. According to the criteria of Perks (1993) and Saks (2012), music therapy in Spain has been making important steps in the process of professionalisation within the last ten years. However, it is necessary to increase our efforts towards the social and official recognition of music therapy by the Spanish authorities, similar to processes undertaken by other European Countries (e.g. UK, Austria and Latvia).

Mercadal-Brotons and Mateos-Hernández (2005) proposed several challenges that should be met for the consolidation of the music therapy profession in Spain. These challenges were summarised in five thematic groups:

1. Academic training of future music therapists;
2. Production of knowledge and publications;

[2] Música, Arte y Proceso (MAP; Music, Art and Process), Asociación Aragonesa de Musicoterapia (AAMT; Aragonese Music Therapy Association), Associació Valenciana de Musicoterapia (AVMT; Valencian Music Therapy Association), Asociación Galega de Musicoterapia (AGAMUS; Galician Music Therapy Association), Asociación de Profesionales de Musicoterapia (APM; Professional Association of Music Therapy), Asociación Castellano Leonesa de Musicoterapia (ACLEDIMA; Castillian Leon Music Therapy Association), Asociación Española de Musicoterapeutas Profesionales (AEMP; Spanish Association of Professional Music Therapists), Asociación Gaditana de Musicoterapia (AGAMUT; Cadiz Music Therapy Association), Asociación para el Desarrollo y la Investigación de la Musicoterapia (ADIMTE; Association for the Development and Research in Music Therapy), Associació Catalana de Musicoteràpia (ACMT; Catalan Music Therapy Association).

3. Ongoing professional training of music therapists;
4. Ethical development of the profession;
5. Social and organisational development of the profession.

In addition, Sabbatella (2008, 2011a) proposed the following:

1. The need to create a Spanish census of music therapists (university and non-university trained) and to establish a Register of Spanish Music Therapists taking into account initial training, ongoing training and professional specialisation following the criteria of the European Music Therapy Register (EMTR).
2. The development of a national music therapy code of ethics by the professional music therapy associations to ensure good practice and ethical development of the profession, to avoid professional intrusion and to raise public awareness of the importance of the profession's scope and professional qualifications.
3. The need to establish appropriate mechanisms to manage the recognition as a regulated profession by the national authorities and its inclusion in the National Occupational Classification to provide a standardised language for describing the work performed by music therapists in the Spanish labour market.
4. The need to define the professional role of a music therapy supervisor to ensure the quality of clinical interventions in order to maintain professional competence and accountability, and differentiate his/her role from that of a practicum supervisor (mentor) in the training period.

In the last ten years different steps have been taken to organise the music therapy profession, and to promote a unified vision of the profession within the labour market. The starting point was the first meeting of representatives of the five music therapy associations which were members of the European Music Therapy Confederation (EMTC)[3] on June 20, 2007 in Madrid (Barajas Airport). Various agreements were reached and signed to establish the operation, duties and responsibilities of the EMTC member associations and regulate the functions of the EMTC Spanish Delegate[4]**.** Points 1, 2, and 3 mentioned by Sabbatella (2011) have been reached. The Spanish Music Therapy Register (REMTA) is operational and the first census of registered music therapists became available in July 2014, including 24 registered music therapists (REMTA).

In addition, music therapy was included in the National Occupational Classification under the heading of Social Sciences – Psychology, with the Code Number 28231062 (http://emprego.xunta.es/cnopro/).

The Spanish music therapy associations which are members of the EMTC (AEMTA-EMTC) produced the following documents:

1. Criteria for being a Professional Music Therapist in Spain (2007)
2. The Spanish Music Therapy Register / *Registro Español de Musicoterapeutas Acreditados* (REMTA) (2009). The REMTA was designed using the criteria of the European Music Therapy Register (EMTR), including the categories (Sabbatella 2011b) specified in Table 1. The Spanish Commission on Accreditation of Professional Music Therapists (CAEMT) was created in 2010 to make the REMTA operational.
3. The Code of Ethics for Professional Music Therapists in Spain, which adapts the EMTC Code of Ethics to national guidelines (approved in 2014).

In recent years, AEMP has developed several documents. In 2008, AEMP started a census of professional music therapists (resident in Spain) with adequate university training for professional practice. This census provides institutions interested in hiring professional music therapists with reliable information on the credentials of the music therapist available for employment in a country where music therapy remains a non-regulated profession. Regarding music therapy training, the subcommittee on European convergence and music therapy of AEMP produced a reference document called *General Guidelines to Assess the Design of University Graduate Music*

[3] Spanish Music Therapy Associations, members of the EMTC in 2007: Asociación Castellano-Leonesa para el Desarrollo y la Investigación de la Musicoterapia y el Arteterapia (ACLEDIMA) - Asociación Catalana de Musicotereapia (ACMT) - Asociación Gaditana de Musicoterapia (AGAMUT) - Asociación Música, Arte y Proceso (MAP) - Asociación de Profesionales de Musicoterapia (APM).

[4] The election of the new EMTC Spanish delegate followed the rules established by the EMTC.

Spanish Music Therapy Register (REMTA)	
Categories	***Criteria***
Spanish Music Therapist Register (Musicoterapeuta Acreditado en España – MTAE)	a. Music therapy degree defined in the document *'Standards for being a music therapist in Spain'*. b. One year of full-time professional experience, or equivalent. c. 60 hours of supervised clinical practice. This can include the supervision hours undertaken during training (20%). d. 60 hours of self-experience (e.g. ongoing psychotherapy, psychoanalysis, systemic therapy, music therapy). This can also include the supervision hours undertaken during training (30%). e. 20 hours of continuing professional development (courses, workshops, congresses and conferences attendance, etc.) connected with the field of music therapy. f. To be a member of a music therapy association that belongs to the EMTC.
Music Therapy Supervisor (Supervisor de Musicoterapia Acreditado en España – SMTAE)	Supervisors are registered music therapists who fulfil these additional requirements: a. Five years, full-time of professional experiences as music therapist, or equivalent. b. Additional 120 hours of clinical supervision. c. Additional 60 hours of self-experience.
Transitional regulation	A period for the recognition of pioneer supervisors has been organised. Registered music therapists who demonstrate that they have been supervisors of music therapy practicum in music therapy training programmes (a minimum of 3,000 hours of supervision of practicum) should be recognised as registered supervisors. This period will last for 18 months to be completed by December 31st, 2015.

Table 1: Spanish Music Therapy Register (Registro Español de Musicoterapeutas – REMTA)

Therapy Programmes in Spain (2008) (*Documento Técnico Recomendaciones Orientativas para Valorar el Diseño de los Postgrados Universitarios de Musicoterapia en España)*, as well as the AEMP Code of Ethics for professional music therapists which adapts the EMTC Code of Ethics to national guidelines (2011), and the *Spanish Music Therapy Research List* (Listado Español de Publicaciones en Musicoterapia 2014).

Results of a study on the current state of music therapy in Spain have been recently presented (Del Moral, Mercadal-Brotons & Sánchez-Prada 2014), based on the information gathered by 104 music therapists (professionals and students) who participated in focus groups. It analyses the weaknesses, threats, strengths and opportunities of music therapy as well as possible strategies to improve the current situation. Some of the issues that were addressed include:

- Strengths: the increasing number of publications in the last years; the organisation of National Congresses of Music Therapy every two years.
- Weaknesses: the lack of knowledge about music therapy by the Spanish society; the structure of music therapy training in Spain at postgraduate level seems short and not deep enough to focus on research methodology.
- Opportunities: the increasing number of available international publications on music therapy and the opportunity to learn from other countries.
- Threats: professional intrusion. The difficulty of working as a music therapist in Spain.

Strategies proposed to improve the situation include: organisation of seminars, courses or lectures about research methodology for music therapists; recover and improve the Spanish Music Therapy Journal; create a music therapy research register; outreach music therapy through social networks; establish an accreditation system; work or collaborate with other music therapists and/or other professionals. Some of these strategies have already started or have been carried out (e.g. the accreditation system called REMTA).

DISCUSSION AND REFLECTIONS

The comprehensive and detailed information about the situation of music therapy in Spain described in this article allow the authors to present some reflections and future trends on the topic. A long journey has been undertaken with many exciting accomplishments. There are, however, several elements which still need to be considered in order

to achieve an organised and mature profession.

Training

Music therapy training in Spain requires a regulatory body to overlook curriculum and staff credentials and experience. This is currently not possible within the university system because music therapy studies are not regulated by national education authorities. This situation has led to some music therapy courses not being directed or taught by trained music therapists and it raises some questions such as: a) should there be a minimum requirement in terms of experience in the field in order to teach on training programmes?; b) how should doctoral dissertations be monitored?; c) should dissertations related to music therapy be co-supervised by music therapists?; d) in order to write a dissertation in the area of music therapy, should the author have professional training in the field?

The EMTR defined by the EMTC, along with the recommendations of the European Higher Education Area (EHEA), have helped to produce general music therapy curricula while maintaining the flexibility and individuality of each training institution. According to Spanish university regulations, the length of studies at master's level is 1-2 years (60 ECTS) which is not enough for an adequate training of music therapists. This means that, depending on the institution, students may have completed their music therapy Master's training without sufficient grounding in practical/internship, self-experience or advanced theoretical issues.

Clinical practice

The establishment of the REMTA is a landmark that promotes practice regulation, but not all Spanish music therapists agree with this type of guideline as it requires professionals to undergo continuous education training and supervision to obtain and maintain the accreditation. Although there is a need to increase the number of professional music therapists who work as clinicians, the authors have observed that, currently, a significant number of alumni who have completed music therapy training programmes have chosen to enter the teaching field rather than work as clinical music therapists. This leads us to an important question: what do these music therapy training programmes actually teach? As mentioned above, it seems that the length of the training is not enough.

A further important issue concerns professional intrusion. It is not unusual to find that professionals in related fields (e.g. a psychologist, a special educator, a music teacher) use the term "music therapy" because they use music as a resource in their jobs.

Research

A key issue here is how to improve the quantity and quality of music therapy research studies in Spain, while the level of training of music therapists is not enough and there are not so many clinicians working, as Sabbatella and Mercadal-Brotons (2014) have informed. It is necessary to create a university working group to draw up a research plan, possibly in collaboration with AEMP, with the aim of promoting ethical issues for research activities, the mentoring of Doctoral dissertations, and an improvement in the quality and reliability of results of research conducted by Spanish music therapists.

Profession

There is clearly a need for professional unity. The organisation of National Congresses provides every two years an important opportunity for professional exchange and growth.

Data presented in this area clearly shows that there are music therapy associations with different aims and objectives in Spain which hinder working together towards the profession as a collective by having often competing interests. This delays the achievement of certain objectives which may lead to the recognition of the profession.

As a consequence of the situation described, many music therapists still regard themselves as solitary individuals with private interests rather than considering themselves as members of a professional group with its collective interests. On the other hand, this tendency towards individuality highlights the need for an organisation as a professional group in order to achieve legal and institutional recognition. This would provide the best support to all music therapists in Spain, and would help integrate them fully within the educational, community and health environments.

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Interview

Glimpses into the challenges and opportunities of a new training programme: The MA Music Therapy programme at the University of South Wales

Elizabeth Coombes

interviewed by Ioanna Etmektsoglou

ABSTRACT

It may be said that music therapy training in the UK has come to maturity since most of the current Master's programmes now have a history of more than a decade. The recently founded music therapy training programme in South Wales seems to have benefited from the existing experience of earlier courses in the UK but has had to take into consideration the unique features of the area in which it serves. In this interview Elizabeth Coombes, the Course Leader of the MA Music Therapy at the University of South Wales, shares with the readership of *Approaches* facts, ideas and ethical considerations regarding the planning and implementation of this new programme. The discussion between Elizabeth Coombes and the interviewer Ioanna Etmektsoglou touches on themes such as the adaptation to the unique local features of the area, the applicants' necessary skills and the interview approach, the development of musical skills during the course, the nature and length of the music experiential group and personal psychotherapy as well as the counselling services provided by the university. Clinical placements and work possibilities for UK and international graduates are also discussed. The interviewer concludes with some thoughts regarding the relevance of the interview to music therapists in Greece.

KEYWORDS

music therapy training; interview process; part-time training; applicants' skills; personal psychotherapy; clinical placements; local unique features

Elizabeth Coombes, BMus, MA, is a Registered Music Therapist (HCPC), university lecturer and musician. She is also the Course Leader of the MA Music Therapy at the University of South Wales, Newport. Since qualifying in 2000, Elizabeth has specialised in working with children and young people with emotional and behavioural difficulties. She uses psychodynamic thinking to underpin her work, and also utilises her considerable experience in community music-making. She has worked on interactive therapeutic music projects in the West Bank since 2009, having an interest in how sharing these skills with non-musicians such as teachers and social workers can enrich their professional practice.

Email: elizabeth.coombes@southwales.ac.uk

Ioanna Etmektsoglou studied Music Education at the University of Illinois (Urbana, USA), from where she received a PhD in (1992). In 2000, she trained as a music therapist at Anglia Ruskin University (UK). Since 1995 she has been teaching courses in music psychology, music education as well as introductory courses in music therapy at the Department of Music of the Ionian University in Greece. She is especially interested in pre-training music therapy education, community music and the development of culture and nature-centred music teaching approaches, which emphasise personal development and the understanding and acceptance of differences.

Email: etioanna@ionio.gr

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INTRODUCTION

I had the pleasure to interview – via Skype – Elizabeth Coombes, the founder and Course Leader of the MA Music Therapy in Wales, a programme which was initiated in 2012 at the University of South Wales. When Giorgos Tsiris asked me to interview Elizabeth about this considerably new music therapy training programme, I was eager to accept the invitation. I could imagine the existence of certain similarities between Wales and Greece as loci for new master's programmes in music therapy, and therefore it was my hope that we – music therapists in Greece – could acquire important knowledge from the way this programme was planned, initiated and established. Additionally, reliable information would be available to prospective students from Greece or other countries who might be interested in music therapy training in the United Kingdom.

As it would probably become apparent to the reader, my initial motives for the interview shaped to a large extent the questions that I asked Elizabeth. The main emphasis was not placed on the programme's content in terms of subjects taught, but rather on its structure and workings at the university and on placements at various community settings or institutions. The discussion also included questions that would probably be of interest to prospective students on issues such as the applicants' prerequisite knowledge and skills, the interview process, academic life at the University of South Wales for UK and international students, as well as information on work possibilities for graduates.

AN OVERVIEW OF THE PROGRAMME: WHY PART-TIME?

The training programme, with its psychodynamic orientation, appeared to me to be quite similar to the course at Anglia Ruskin University where I trained in 2000. One of the things that seemed unique to the programme at the University of South Wales was its structure, in terms of the attendance schedule. As I was informed by Elizabeth, it is a part-time, three-year course with one day per week at the university during the first year, one day at the university and one day on clinical placement during the second year, and one day at the university and two days on placement in the third year.

To my question "Why did you choose to start a part-time course?", Elizabeth responded that the decision to offer a three-year part-time course as opposed to a full-time one was driven by market research, which investigated the needs of the prospective students, given the geographical and socio-economic unique features of Wales. She explained:

> **Elizabeth:** People here are very economically and socially deprived in comparison to the rest of the UK. Also, large parts of Wales are very rural, so the idea of travelling for more than one day a week to study is not practical for people. No-one surveyed said they would like a full-time course.

It came as a surprise to me the fact that, while there are about 700 music therapists in the UK, there are only 22 in Wales as indicated by the Health and Care Professions Council (HCPC) and the British Association for Music Therapy (BAMT). These few music therapists, according to Elizabeth, are situated in the most populated areas of the South and the North of Wales, while there are very few music therapists in the central area. Most of the prospective students would have to travel a considerable distance to the course or to placements. She explained the situation further, saying:

> **Elizabeth:** I have a student who drives 170 km one way for this one day a week at the university and sometimes to get to a placement with a music therapist, they have to drive the same distance.

Given the fact that the students might have to work so that they could support themselves, pay for the course and, if they are mature students, may have further family responsibilities, Elizabeth and her team decided to spread the course over three years, instead of two, so that the prospective students could possibly continue their work with some adjustments and commute to the university for one day per week. Elizabeth pointed to the vast differences between the course she directs in Wales and other music therapy training courses which are full-time. She said:

> **Elizabeth:** It's not like London where there are more courses that are full-time. Courses have so many placements there, they can pick and choose! Students can pick up some pieces of work much more easily when they qualify [...]. It's completely, completely different, and I think people really don't appreciate that things like the economy and the geography will drive […] what provision is going to suit that particular part of the country.

Indeed, from the short time since the beginning of the course, it seems that the three-year part-time programme has been a suitable choice for candidates not only from Wales but also from different parts of the UK. To further assist the commuting students, Elizabeth tries to find placements near the area in which they live.

THE APPLICANT'S MUSICAL SKILLS

But who might be the students on this course and, more specifically, what should be their musical background? Moving on to the subject of the musical skills of student applicants, I raised the question: "If the international students or even the UK students play a traditional instrument can they use it as their main instrument on the course?" to which Elizabeth replied:

> **Elizabeth:** Yes they can. In fact, when the HCPC came to look at our programme before it was approved, one of the big questions for them was, how do you assess musical skills if the candidate is not, for example, classically trained? Say, for example, someone wanted to become a music therapist and their main instrument was Information Technology-based. Maybe he was a DJ, or didn't play the piano. You can't bar that person, because that person might be fantastic as a music therapist. You have to find a way to work out if the candidate has the potential to be a music therapist and if he/she is musical enough with the ability and willingness to develop their musical skills. The question is: How would your interview process assess that person and how would you word your prospectus so that the people who don't have the traditional music exams understand that they can still apply? What we say is that in your first instrument you need to be at a standard above Grade 8. This does not mean that you have to have done formal exams, but you have be able, on whatever is your first instrument, to play to a professional standard. We don't specify what the first instrument is, but like people to have also a second instrument, hopefully one of which is an accompanying instrument.

AGE VERSUS MATURITY OF PERSONALITY

The demands of a music therapy training programme could be quite overwhelming for a young student. Several years ago, as I remember, music therapy training courses in the UK tended to have a minimum age requirement for entry. So I wondered if this is the case today for the programme in the University of South Wales. Elizabeth informed me that this is not the case any longer in any of the training programmes in the UK, because the specification of a minimum age would be in violation of the Equality Act 1990. Therefore, according to her, when a person applies to the programme, the deciding factor would not be his or her age, but the maturity of personality and their life experience.

THE INTERVIEW PROCESS

The next subject I introduced was the student interview, which is an important part of the evaluation for admission to the programme. On this programme, the interviewers do not ask for recordings, but conduct live interviews with all applicants. Elizabeth said about these interviews:

> **Elizabeth:** I am happy to meet people. Even if they are not yet of the right standard, if I think that they've got potential, I'll say to them you've got potential, but you need to go away and work on your music skills, you need to practise, you need to bring yourself up to the necessary standard. And I am happy to do it and that's quite specific I think to the fact that I am serving an area that's always been deprived, so I am perhaps looking at people who haven't had a chance to get those music skills or they haven't been able to receive input. So I can advise them how to move forward in their chosen career path and that's what I do.
>
> In the interview process, we have a group improvisation session with which we start the interview process. Maybe five or six candidates are asked to participate in an improvisation. Part

of that is to see really whether they have the right skillset and how they think about improvising, connecting musically. It doesn't mean that they have to be fantastic improvisers. This is also for people to think: "O God, this is nothing I want to do. I made a mistake. It isn't what I thought it was". It can give them a taste of what music therapy is, because maybe they don't really know. They see this term 'music therapy' and it sounds lovely but they don't really know what it is. After the improvisation they have an individual interview and we ask them to perform individually to a panel of interviewers.

We want them to have a good experience at interview as far as possible and, even if they were not good enough to get a place, they hopefully learn something. They had a musical experience, they met some other people and, if they are not the right people for the course, it might give them something else to think about, something to go away with. I think that's a responsible way to operate our admissions procedure at the moment. Maybe if I had 70 or 80 people applying for the course there is no way I could interview such a high proportion of candidates. I would then be asking for the recordings to select those to be interviewed. But at the moment it works really well like that. I hope to fill the course by late spring 2015, but during the summer I might get a few people applying so I keep a couple of places. These I will interview individually. The better way is having them in groups, but in practice it never works that perfectly, I'm afraid.

It's actually quite a fun process. You see what they can come up with really. I am quite flexible about it. People get pretty anxious. […] They would ask me "what do you want me to play?" and I would say: "Something that will show you at your best as a musician. Don't play what you think I want to hear, play what you really like. It doesn't really matter if it is something really simple, because the important thing is the musicality".

MUSICAL DEVELOPMENT DURING THE COURSE

Once accepted to the training course, I wondered how the students are facilitated in furthering their musical skills and sensitivity throughout the three-year programme. Elizabeth explained:

Elizabeth: During the first year they have two hours a week of what we call clinical improvisation. There is a clinical tutor for that. And that's looking at all kinds of aspects of working therapeutically, from choosing instruments, to role playing, to improvising. Sometimes people obviously have never improvised before. There are different levels of musical competency or there is a lot of fear about not being as good as other people. So we work through that in the seminars. At the end of the first year they have a clinical improvisation assessment. Each one of the students facilitates a 20-minute improvisation with three other students, and then they facilitate the discussion. This is working really well. It's not role play, pretending to be people with disabilities. The idea is to support each other. The facilitator sets the instruments out, sets the room up and then just sees what happens. I hope it is a really useful learning experience for them; it's not just an exam they have to do. And in the second year, they get a similar input again for another two hours a week. This second year music-based seminar can also be a chance to work with musical techniques they are using in their clinical placements. Role playing and peer support is helpful for them here, as well as continuing work on clinical improvisation skills.

We also have the art psychotherapy course and some of the theory seminars are joint. At the end of the first and second year the art psychotherapy students put on a show, an exhibition, for which they choose the venue, and the music therapy students go along at the opening and they improvise around the artworks that are on show. It's very useful to have both modalities because it makes the students, and us, really think about what the specialisms of their particular chosen field are.

THE MUSIC EXPERIENTIAL GROUP

The experiential group, whether verbal or music-based, plays quite a central role in music therapy training. Elizabeth talks about the experiential group within the training programme at the University of South Wales.

Elizabeth: In the third year, the students do not have a taught seminar but they have a facilitated music experiential group. So we have a music therapist facilitator on the site and it's a purely experiential group. In the first and second year they have experiential groups but they are verbal. Most of the music therapy trainings in the UK have an experiential verbal group. But ours have two years of verbal experiential groups and a third year of music experiential group

Ioanna: Is the verbal experiential group for both music therapy and art psychotherapy students?

Elizabeth: No, the verbal experiential group consists of only music therapy students. It's facilitated by a group analyst. The facilitator for the last two years has been an art psychotherapist, but that's purely by chance, because the art psychotherapy students have

their own experiential groups in which they do art. They have an art-based experiential group every year but ours is different. And that's partly because I think there is a level of teaching that needs to take place in the music, for the clinical improvisation is a quite specific skill. But also, the verbal experiential group is to help the students really think about how they work in a group, what and how relationships form and how group dynamics change. Much of music therapy work, more so than art psychotherapy, is group-based certainly in the UK.

PERSONAL PSYCHOTHERAPY

Ioanna: Personal psychotherapy is of utmost importance in the training of professional music therapists. I was quite impressed by the fact that the programme at the University of South Wales requires that the students have personal psychotherapy during the three years of the course.

Elizabeth: In practice, it's from when the course starts in September to when it finishes in May, three years later. It's thirty weeks per year and it's probably the most of any course in the UK.

Ioanna: That's great!

Elizabeth: I think so. The problem with that is that it's a bit expensive, obviously. But a lot of past students on other courses and our students on the course find that it's so worthwhile, so supportive.

Regarding the choice of a psychotherapist and the process followed by him/her and the student, Elizabeth said:

Elizabeth: We don't keep a list of therapists (art therapists, music therapists, psychoanalysts or psychotherapists) that we approve, they are all so geographically spread everywhere, but we do have some requirements that they have some form of registration. We do ask that the therapist has been practising for at least five years and we do keep registration forms for each student. The therapists have to send us a form every year to say that the student has completed the thirty sessions as required.

CLINICAL PLACEMENTS FOR MUSIC THERAPY STUDENTS

Finding an adequate number of clinical placements in an area where music therapy is a considerably new profession could be a challenge for the training course organisers and students. With regard to this Elizabeth said:

Elizabeth: I don't have many placements in Wales with music therapists, because we've not got many music therapists; plus, if the point is for people to qualify and then get a job as a music therapist, it's very helpful for them to be doing placements near where they are going to be living and then they can network and make contacts.

Elizabeth gave an example of one of her second year students who had been working at a placement providing sessions until he would qualify, at which time he could be employed as a professional music therapist. She commented:

Elizabeth: It's brilliant! Obviously one of the first questions people ask when they are deciding to take the training is: "Am I going to be able to find work? Would this investment of time and money and - let's be honest - stress, in putting yourself through it, mean that I'll get a job?" It's all very well saying "don't worry about that, that's three years away..." or "I don't have a crystal ball to look into the future...". But if people are spending money, they want to know if they can get a job. I'm sure that would be pretty much the same in Greece.

Ioanna: Oh yes, especially now with the economy being so bad...

We continued the discussion about clinical placements. When I asked "how long is a placement?" Elizabeth said:

Elizabeth: Well, all universities have quite different lengths of placements. We have an overall minimum number of 528 hours. What we say is that they have to do a full day contact time at the placement. Obviously they are not doing sessions all that time, but the point is to work there, in some places for a 9am to 5pm day or 9am to 3pm day in the school, to understand the rhythm of the school, to experience things like the dinner time and playtimes so they can understand how it works for the children. On top of that time, they need to review their sessions and write their own notes in their spare time on placement. Obviously there would be quite a lot of reflecting and thinking about their work to be done in their own time as well.

The HCPC is very strict on how you have your mechanisms set up in terms of quality controlling the student's work, quality controlling the placement and what you do if a problem arises. There is a separate handbook for the placements, which states clearly the responsibilities for the course, student and placement. So the clinical placement supervisor – that's the one on-site – has clinical responsibility. We also have weekly group clinical supervision at

the university. So there is supervision done at the placement and there are some places that are able to offer that on a weekly basis, but if they can't, if there is no time in the therapist's workload, what we say is that as long as there is someone on hand to deal with any problems, that is OK. We like to think that the student is getting an hour's supervision – one every two weeks. So far, we have not had a problem. Obviously the placement therapist/supervisor is responsible for the client so they want to make sure that everything is OK.

The way our placement works is that in the first year students don't do a clinical placement because we have the infant observation and they do a six-week observation of a placement. In the second year, they do 20 weeks of one day a week and in the third year it's two days a week for 20 weeks. What's happening in practice is that some placements are saying that's too difficult for them and so we would change it. The student might go 40 weeks for one day a week in that placement, and they can start doing that in the summer. They can spread it out a bit if that's better for the placement. But in either case, at the mid-point of the two clinical placements there are forms to complete which allude to the relevant areas of the standards of educational training and practice. These ask for comments about areas such as theoretical knowledge, relationships on the placement, the musical skills, being able to explain the nature and purpose of therapy to clients, the service-users and their families, and so on. The student completes one assessment form themselves, the placement supervisor also completes one too, and then they both share these forms in a supervision session. The student is then given targets indicating strengths, what things need improvement and so on.

It actually is very difficult assessing placements, because every placement supervisor is different. I think it's an ongoing issue for all courses. How do you get a student the same experience in each placement? Obviously it's not possible. Our forms are not perfect but they help us do the best we can. And, of course, because we have small group supervision at the university in which they bring film of their clinical work, you have the chance to watch clinical work, so this does enable you to see what is happening on placement.

The university supervision takes place every week in years 1 and 2. Because there are only eight students, they meet in two groups of four. I supervise one group, my colleague supervises the other. Each student gets a chance to present every other week, getting 40 to 45 minutes. That's proved to be really successful and letting people see other people's work with different client groups, and to all think about that together plays a really vital role in the course. And, of course, it's great fun supervising students.

WORK POSSIBILITIES AND NETWORKING

We had already discussed work possibilities in the context of the clinical placements, but now Elizabeth focused more specifically on the subject, emphasising the importance of making network connections and building possibilities. She said:

> **Elizabeth:** […] the students are all adults. They've got to be responsible for their own learning, and I suppose that gives them a head start in what it might be like to be a music therapist. There are not that many jobs, in the sense that you get your holiday pay, your sick pay, you work nine to five. It might be freelance work, it might be doing one day a week, two days a week. It gives them a sense of what the possibilities are, because in some ways having a variety of clinical work like that can be a good thing. It also gives them a chance to see where they feel their natural therapeutic strengths lie.

INTERNATIONAL STUDENTS ON THE PROGRAMME

Having discussed in depth about clinical placements, I introduced the subject of international students who might consider enrolling on the programme. For an international student studying abroad, I wondered whether the three-year part-time scheme would bring an additional financial burden in comparison with a two-year full-time course. Elizabeth responded by saying that based on her experience with the international students who have been taking the course so far, including a Greek student, she believed that they are quite resourceful in looking for work. Actually, the Greek student she mentioned was able to receive a research grant from the university to do some work and she also goes home in the summer and might be doing some work there as well.

> **Elizabeth:** We are very lucky at USW that our Centre of Excellence in Learning and Teaching (CELT) regularly offers lecturers small grants to further research. There is always an element of student input in these grants and the budget contains money for student work. This is not only valuable experience for students to begin research work, but also a help financially. The MA Music Therapy has so far received 2 CELT awards.

Another issue we discussed later on, which would be of interest to prospective international students is the rather low cost of living in Wales in

comparison to cities in other areas of the UK.

Concerning the level of English proficiency required for the course, according to Elizabeth, most universities in the UK ask for an IELTS (International English Language Testing System) 6 or 6.50.[1] However, the HCPC sets the minimum level of English proficiency for music therapy students at level 7 of IELTS.

THE STUDENTS' SUPPORT SYSTEM AT THE UNIVERSITY OF SOUTH WALES

Even students with mature personalities can be susceptible to some challenges brought by experiences from the training course or from their personal lives. The University of South Wales according to Elizabeth has a very strong system to support its students. In her words:

> **Elizabeth:** We do have quite a robust student support system at our university. This has been an award winning sector of the university and that's simply because where we are located used to be the very deprived parts of what was called the South Wales Valleys, which used to be the coalmining areas. Since the coalmines are virtually all closed, there is a lot of unemployment, and in order to get people back into education training – there are families where nobody had a job, let alone going to the university – in any educational establishment it's very important to have strong academic support and strong counselling support, this more so when students are undertaking a complex area of study where they are asked to work reflectively and reflexively. In reflective practice, the student learns from their experiences on the course through a process of reliving and re-rendering learning and practice. Reflexivity involves finding ways to question their own attitudes, assumptions and prejudices, trying to understand their roles in relation to others. The University of South Wales also has an emergency counselling service for students with a certain number of free sessions. Our MA Music Therapy students are not allowed to count that towards the personal therapy hours they have to undertake, but if you were in a crisis or there was a problem, there is a lot of support there. We also have free English classes for foreign students.

As Elizabeth explained, the support for the students is not available only at university level, but it is also provided at the level of the music therapy training programme.

> **Elizabeth:** All students have a personal tutor, which is either me or another music therapy staff member. I always say, if there is a problem they must bring it to their tutor rather than letting it fester, come and talk to one of us. We use Skype or tutorials to try to be available to support them really, and that's as much as any to try to model a good professional practice.

CONCLUDING THOUGHTS

Having addressed the last theme of student support we arrived at the close of the interview. It was very interesting for me to be guided through the setting up and implementation phases of this music therapy training programme. Elizabeth, as the founder and Course Leader of the MA Music Therapy Training Programme at the University of South Wales, was very kind to share with me and the readers of *Approaches,* not only detailed factual information but also some important thoughts and ethical considerations that characterise the programme.

It became apparent to me that this three-year part-time music therapy training was designed and is being implemented with a particular sensitivity to the needs of the students from the area it serves but also for those from other parts of the UK and abroad. In listening to Elizabeth talk about the programme, I also recognised important similarities between the students' needs in South Wales and in Greece which could be traced back to contextual similarities. Before the establishment of this training programme, the two areas, South Wales and Greece, despite their cultural and historical differences shared at least three important features: a) a degree of economic deprivation, b) the lack of an existing accredited MA music therapy training (although there had previously been an accredited music therapy training in Wales that ceased in 2010), and c) an uneven geographical distribution of appropriate placements. The three-year part-time training programme was designed according to Coombes as a response to the students' need to continue working in order to support themselves financially while pursuing the training. This need is probably even more pronounced in Greece during recent years. If this is true, should a music therapy training programme in Greece be likewise part-time or not? Learning from the programme of the

[1] This should be understood in the context of the banding system being from 1-9, with 1 meaning "no ability to use the language beyond a few isolated words" to 9 being "expert user". Level 7 is described as a "good user" [...] "Handling complex language well and understanding detailed reasoning".

University of South Wales, finding out the opinions of the possible trainees might provide the answer.

The new training programme in South Wales seems to have incorporated in many respects elements of existing music therapy programmes in other parts of the UK with which it is much closer geographically, culturally and historically, than is Greece to the UK. Much of the experience gained from the establishment and development of music therapy programmes in the UK and in other countries around the world could be especially useful when considering the establishment of a Greek music therapy training programme. However, important consideration should be given also to the differences in geography, history, culture, and especially in music and the ways in which local people express themselves through it and assign meanings in various contexts. Music therapy training, therefore, could be informed but not copied from existing programmes in other countries.

In the South Wales training programme, extra effort seems to be applied both by the staff of the training programme and the students with the aim to locate and create new possibilities for placements even in remote places. A similar and greater effort would be expected in a Greek context of music therapy training, given the fact that some students might have to travel for the course or for placements to the mainland or to other islands.

Beyond practical matters the provision of psychological support and means for self-awareness and development throughout the programme alongside the musical development, seemed to be an important priority in the training programme in South Wales, as I had experienced it when I trained at Anglia Ruskin University. Personal psychotherapy, supervision both at the university and on placement, and a more general provision of counselling services by the university seem to be essential for the realisation of the music therapy training objectives and would be of utmost importance for a music therapy training programme in Greece.

Suggested citation:

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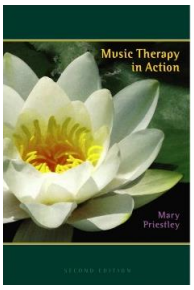
Book review

Music Therapy in Action (Mary Priestley)

Reviewed by Kay Sobey



Title: Music Therapy in Action (2nd Edition) | **Author:** Mary Priestley | **Year:** 2012 | **Publisher:** Barcelona Publishers | **Pages:** 270 | **ISBN:** 978-1-937440-15-2

Kay Sobey was Convenor of the PostGraduate Diploma/MA programmes in Music Therapy at Roehampton University from 1990-2005. Her most recent clinical practice was with children under five and their families in a Child Development Centre. She now works for The Music Well in Rye in a mainstream primary school with children who have behavioural and emotional problems. She is also part of the editorial team for the *British Journal of Music Therapy*.

Email: kaysobey@outlook.com

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It is both a privilege and a challenge to attempt to review a book which has such great historical significance for the music therapy profession, especially one that has had wide readership internationally. *Music Therapy in Action* was originally published in 1975 with a second edition in 1985. Barcelona Publishers have now reprinted that second edition and many will be grateful to them for once more making it available after several years out of print. Four sections (pp. 106-138) from the book are reproduced in Priestley's later publication, *Essays in Analytical Music Therapy* (1994).

Written, not only near the beginning of the author's career as a professional music therapist but also early in the development of the UK music therapy profession as a whole, the book is wide ranging and packed with information and insightful reflection on both theory and practice. Much of this remains relevant today. There is a very detailed table of contents showing that the book is divided into 32 chapters, each with several subheadings, making it easy to locate a topic of particular interest. This is fortunate as, in my opinion, the way the material is presented does not lend itself to being read straight through from beginning to end. Rather I would recommend it as a rich treasure trove of ideas and words of wisdom making it both useful and a source of inspiration to music therapists. Additionally it provides a valuable resource for anyone interested in the early history of music therapy training and clinical practice in the UK.

Priestley's Foreword reminds the reader of just how different the professional context for music therapy was when it was originally written. Despite this, the book still fulfils one of her stated purposes in writing it by cogently answering the questions "What happens in music therapy? What do patients do? How does it work?" (p. xv). The invaluable Introduction which follows (pp. xvii-xx) was provided by the consultant psychotherapist Gerald Wooster, to whom the book is dedicated. In this he gives a thoughtful and persuasive endorsement of the usefulness of a psychoanalytic approach to music therapy – particularly with psychotic clients. He brings to our attention the dangers as well as benefits when working with a medium (the music) which has the potential to undermine defences – warning against naivety and stressing the importance of a therapist capable of providing adequate containment.

Chapter 1 immediately provides some answers to the author's key questions, with a directness

praised by Leslie Bunt in these words "[w]here is a more well-written page defining music therapy than in the opening section of her first book […]" (Bunt 2004). The last of this chapter's five sub-sections is a brief summary of those concepts from the theories of Freud, Adler, Jung and Klein that she finds the most relevant to her approach to music therapy. By then it has become clear what makes this book so exceptional: the author is a master of the English language and expresses herself as fluently and vividly in words as she undoubtedly did in music. She can produce succinct definitions of complex theoretical concepts in such a way as to make them instantly accessible.

The remainder of the book is presented as falling into three parts: Preparation; Practical Experiences and Techniques; Thoughts Around Music Therapy. Although Part One makes fascinating reading (especially for anyone involved with training), it is largely of historical interest as the training programmes and working environments have undergone so much change and development since this was written. Nevertheless the intensity of experiences in training, particularly descriptions of being taught improvisation, will resonate with many more recently trained therapists.

In contrast to this it is hard to ignore some discomforting outdated terminology, and occasionally somewhat dismissive descriptions, for example in the section headed Choosing a Field of Action (pp. 27-32). Reading this might leave the reader with the impression that there were considerable limitations to ways of working as a music therapist with non-verbal clients or children, particularly those with a learning disability. It has to be remembered that this book preceded the work of Valerie Sinason and her Tavistock colleagues in the 1980s. Their clinical work, research and teaching (Sinason 1986, 1992) notably challenged this view showing how psychoanalytical psychotherapy could be used effectively with those who had difficulty expressing themselves in words. This had a profound effect on subsequent clinical practice, especially that of music therapists whose fields of work were enriched and greatly expanded thereafter.

Included in Part One is the first introduction to Analytical Music Therapy (AMT) and Intertherap for which of course Priestley is best known and rightly acclaimed. After initial definitions and description of its inception she emphasises that the music therapy qualification alone was then "not sufficient to practise as an analytical therapist" (p. 20). She continues by writing that the pre-requisite for doing so is "a special kind of interpersonal and intrapersonal experience" (p. 20) specifying the need for undergoing one's own analysis or least being supervised by an analytical psychotherapist. Intertherap(y) was developed to become another essential ingredient in this self-exploration. We know now that UK training programmes were expanding in the late 1980s and were to grow ever longer to reach the two-year full-time MA programme that is currently the requirement for qualification. Within this they have all come to include greater emphasis on experiential learning and mandatory personal therapy – although this might not be with a therapist of psychoanalytical orientation. Priestley herself benefitted from having her own analysis with a Freudian and supervision from a Jungian analyst. She also undertook further training in groupwork and family therapy from the Institute of Group Therapy (IGA). This formed an unusually rich background of knowledge and experience for developing her own psychoanalytical approach to music therapy. Although Chapter 3 (pp. 19-26) is appropriately included under Part One: Preparation, some readers might find it more helpful to read, or re-read, it in conjunction with Chapters 14-16 where AMT theory and practice are explored in more depth.

Chapter 5 concludes Part One with practical suggestions for repertoire and instruments. This is an example of information which has inevitably become dated and therefore less likely to be found relevant and useful in current practice. To me Part Two, *Practical Experiences and Techniques*, is the heart of this book, not least for its emphasis on detailed descriptions of her casework. As with other psychoanalytical authors, from Freud through Yalom to Grosz, I have always found that theory becomes most intelligible and meaningful when it is conveyed through descriptions of clinical practice. Through Priestley's ability to bring her work with patients to life we engage with each individual's therapy process and the author's warmth and authenticity shines through. This reminds us that research into efficacy has often indicated that the therapists' personal qualities are as likely to be the factor promoting change as the methods they employ and the theory that informs them.

Chapters 6-13 describe all the areas of work that were undertaken by music therapists in the 1970s/80s within large old-style psychiatric hospitals and asylums. I found this particularly interesting because of the diversity of roles and activities that were then expected of the music therapists – not least because I worked in a similar context towards the end of that period. It may surprise new readers, or those only familiar with

Priestley's later publications, to find descriptions headed *Therapeutic Teaching*, *Record Sessions* and *Psychodynamic Movement/Relaxation*. The long-running issues such as what differentiates music therapy from the therapeutic use of music or the case for using familiar repertoire and performance (mainly classical music in her case) rather than improvisation are all addressed. She tells us with characteristic clarity that for therapy

> "[t]here must be three factors […] the client, the music and the therapist. Where there are only two, the client and the music, the experience may be therapeutic but there is no therapy […] Human relationship is an essential ingredient […]" (p. 1).

It is clear throughout that whatever 'action' is being described her therapeutic thinking is the core of the work and informs all the relationships with her clients. This gave her exceptional insight and understanding of their inner worlds which could transform what might otherwise have been mundane or more superficial experiences.

Chapters 14-16 focus on AMT in more detail by describing numerous *Techniques* (pp. 106-132). These together with *The Emotional Spectrum* (Chapter 17, pp. 133-138) are the sections later reproduced in *Essays on Analytical Music therapy* (1994). They demonstrate precisely how the author would make use of both her vast knowledge of analytical theory and her own personal experiences in analysis and Intertherap. Some techniques may be more familiar as resembling the work of those trained in and practising Guided Imagery with Music (GIM). Others closely relate to the practice of today's drama therapists or dance movement therapists. They are helpful as illustrations of the application of her theoretical approach and especially so when described in context as occurs later in her *Case Studies*. Good examples of this are Chapters 20 and 21 *Music Therapy with a Private Client* (pp. 155-161) and *Notes on a Hospital Patient's Music Therapy* (pp. 162-180). It is possibly debatable whether it would be advisable to take them too literally as a model for close imitation. They seem to me very much part of the author's own personal style and also to require the rigorous amount of analysis and supervision she referred to earlier (p. 20)

Part Three is made up of a further eleven chapters. These are once more divided up into sub-sections, some of which are very short. Chapter 23, *Inner Music* aroused my interest particularly. This she defines as "the prevailing emotional climate behind the structure of someone's thoughts" continuing "[it] is the music of 'how' rather than 'what' […] the music of adjectives" (p. 189). It is clearly something she greatly relies on to inform her musical responses together with transference and counter-transference. The use of the latter in music therapy is explored in Chapter 29 which provides another example of the author's ability to give succinct and useful explanations of psychoanalytical thinking.

The remaining sections are more general musings on wider aspects of both music and therapy. Reactions to these will depend a great deal on the personal experience and viewpoint of the individual reader. An important aspect of the author's writing is that it is always thought-provoking but its very strength means it is also likely to arouse an emotional response. Personally I found much to appreciate in Chapter 22, *The Aims of Music Therapy*, and its sub-section *The Functions of the Therapist* (p. 182). On the other hand I struggled with Chapters 25 and 31. *Discussion of The Meaning of Music* (pp. 244-250) are almost inevitably controversial. For me assertions as to the effects of specific pieces of music, or even the elements thereof (p. 206), are at best arguable but other readers will doubtless have entirely different reactions and preferences.

It is to be hoped that a generation of new readers will be surprised and delighted by this book. Those who are familiar with *Essays in Analytical Music Therapy* (1994) will still find much of interest in reading more about its early practice and developments. As Bunt comments following his interview (2004), Mary Priestley appears to be better known and more widely appreciated outside her home country. This reprint will remind us how innovative her thinking was at the time of both first and second edition and of its lasting impact on music therapy ever since.

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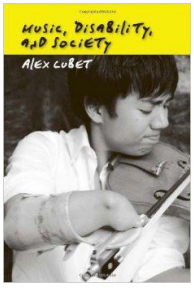
Book review

Music, Disability, and Society (Alex Lubet)

Reviewed by Sherrie Tucker



Title: Music, Disability, and Society | **Author:** Alex Lubet | **Year:** 2011 | **Publisher:** Temple University Press | **Pages:** 264 | **ISBN:** 978-1439900253

Sherrie Tucker is Professor of American Studies at University of Kansas. She is the author of *Dance Floor Democracy: The Social Geography of Memory at the Hollywood Canteen* (Duke UP 2014) and *Swing Shift: "All-Girl" Bands of the 1940s* (Duke UP 2000), and co-editor, with Nichole T. Rustin, of *Big Ears: Listening for Gender in Jazz Studies* (Duke UP 2008).

Email: sherrietu@aol.com

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Alex Lubet's *Music, Disability, and Society* (2011) is crafted as a series of provocative essays that taken together, posit a set of ideas and approaches of significance to fields of disability studies, musicology, ethnomusicology and music education. Although music educators and music therapists are not the only intended audience for this book, it is a valuable contribution for readers in these areas in a variety of ways, not the least of which is that its imagined readership explicitly includes people with disabilities who have been shunned by music education and musicians who have been disabled and/or impaired by the musical cultures to which they are devoted (a much larger group than one might think). More broadly, *Music, Disability, and Society* addresses all people seeking more inclusive and adaptive musical cultures that presume the interdependency of all bodies, not the dependency of some and the autonomy of others. This orientation holds tremendous implications for many communities of readers, not the least of which are music educators and music therapists.

Lubet is a Professor of Music at the University of Minnesota; a composer, improviser, and performer; and one of the leading (and one of the earliest) scholars of disability studies and music, along with Neil Lerner and Joseph Straus (see Lerner & Straus 2006). He is the author of many articles on disability and music, and co-editor with Na'ama Sheffi of a ground-breaking two-volume special issue of *The Review of Disability Studies* devoted to music in 2008. Unlike most of the disability and music scholars, Lubet's practice-based focus has led him away from "disability and music" as a sub-interest of musicology (and a growing one at that), in order to situate musical cultures and musical practice within the field of disability studies. In this way, he extends the repertoire of interest beyond therapeutic applications, 'good' and 'bad' representations, and close readings (critical or not) of heroic biographies of superstars who overcome adversity (or "supercrips" in the language of disability rights activism and disability studies), and toward a more practice-based, practitioner-centred analysis in which disability is not something a person has, but as an effect of social constructions of what counts as a normal body. How these social constructions have affected the lived lives of musicians is at the heart of Lubet's essays, or "encounters" as he calls them.

The theory of "social confluence" that Lubet develops through the case studies in *Music, Disability, and Society* insists on disability and impairment as fluid aspects of social status that

people navigate in cultures; aspects that are in no way 'fixed', but may in fact change many times in the same day. He grounds his analysis in the cornerstone of the social model of disability studies and builds a serious consideration of the role of music in social constructions of these dividing lines of normal/abnormal: "What disables musicians comes not only from large external social forces such as legal and insurance systems, but also from within musical cultures themselves" (p. 30). He grounds his analysis in his own experience as a music professor whose injury in 2000 led him on a journey through his profession and day-to-day work life that involved moment-to-moment "identity-transformations" that shifted according to "social, cultural and institutional context" (p. 2). His long and frustrating navigation of seeking accommodations that would facilitate his return to work radically changed how he thought about music. Though the topics of his chapters range from left-handed pianism, the disabling effects of Western Classical music, improvisation and aesthetic values of difference, questions of blind culture and music, and religious organisation of gender and music, his most radical critiques are aimed at university music programs such as the one where he currently teaches. Whether or not one is connected to such a program, he raises many points of critical significance for music educators and students.

Lubet's book opens with an introduction that lays out his theory of "social confluence" (pp. 1-2) as a way of talking about what it means to navigate social and professional life when one of the many socially constructed identity categories and embodied experiences inhabited by a person is shaped by disability and/or impairment. His introduction also deftly exposes musical false binaries of adaptive/autonomous, limits/limitless-ness, dependence/independence that disability studies do so well. Two of the fell swoops that were levelled in this as examples include 1) exposing the false distinction between musical composition and adaptive composition, and 2) the folly of thinking that interdependence is a sign of weakness of any culture, including musical ones. Reifying composition at its highest form as not adaptive to limitations ignores the parameters composers must obey if they want their pieces to be performed. Without observing the limitations of instruments and players, even if one presumes an army of supposedly "able-bodied" virtuoso musicians, the composer would write music with little likelihood of performance. On the other hand, composition in which instrument parts are written within the limitations of the instrument and within reach of the typical ensemble is not only adaptive, but a form of standardisation of tastes, training, and bodies. If that piece is playable only by a class of musicians valued for a very narrow range of abilities unattainable even by second-tier players, it contributes to an exclusive aesthetic that supports virtuosity as an ideal, but also necessitates and promotes 'standardisation' of goals, training, and practice that can injure musicians of all abilities. This is one of many moments when Lubet grounds his argument in disability studies insights; it is not "that people with disabilities are dependent, but that all people are interdependent" (p. 6) and shows us how to productively apply this to musical cultures, including education.

One of the most important insights of this book is Lubet's observance, developed throughout, of the large (uncountable) numbers of injured musicians, who play while injured, rather than face the many professional dangers of disclosure. To analyse musical cultures within disability studies, rather than to pose such questions within a disability studies "sub-interest" of musicology, is a move that Lubet effectively mobilises to discuss western classical music as a culture in which to admit injury is to fail at achieving or maintaining legitimacy as a musician – even though it is the standardisation and its cultural and professional disavowal that holds up this ideal.

This first "encounter" he develops is an exploration of one-handed pianism as a lens for further developing his analysis of standardisation of bodies through repertoire, practice and western classical musical culture, His focus on the critical and audience reception of differently-disabled artists was especially fascinating in that it discloses a hierarchy of worthy and unworthy artists with disabilities in a way that completely disconnects the disability and impairment from the ability for that musician to perform musically. His pragmatic focus on how the ADA (Americans with Disabilities Act) and Workers Compensation raises questions about what it means for a hand-injured woodwind player to not qualify for accommodations and to silently disappear from the symphony orchestra, while Itzhack Perlman's inability to walk without a cane is recognised as disability, and greeted with applause in critical reception, even though his impairment does not interfere with his playing. I found his discussion of differential reception of hand-injured pianists who have two hands but play with one in comparison to one-handed pianists especially

enlightening on this issue. Lubet's practical approach to embodied effects of disabling effects of musical cultures leads him to consider all aspects that affect performers, including the repertoire available for artists defined as disabled. If composition for one-handed piano is seen as limited, while composition for two-handed piano is considered to have sublime possibilities, it isn't surprising that the latter comprises a very limited repertoire.

Continuing with his application of "social confluence" theory as it illuminates lives of working musicians, Lubet covers such ground in this chapter as how the Americans with Disabilities Act (ADA), Workers Compensation insurance, and human resources departments define disability and extend accommodations to musicians as workers in western classical music. His comparison of orchestral labour and accommodations with professional sports labour and accommodations illuminates a startling difference: In the latter, there exists a "disabled list" whereby temporarily impaired players can recover without losing their jobs. Most symphony orchestras in the USA do not have such protection (pp. 23-24). Throughout this chapter, he continues to develop the many ways in which western classical music, in the USA context, comprises a culture that is intolerant of difference and actually impairs its practitioners. Such a situation is argued by Lubet not to be inherent in composed music and musical approaches to repertoire and instruments. In fact, arrangement and improvisation are both "potential sources of disability accommodation" (p. 40). He identifies a disabling turn when improvisation disappeared from western classical music after Beethoven's death, only to be replaced by the "canonisation of 'inerrant' texts'".

Lubet finds hope in "musicians who have been able to craft a praxis around their impairments, to perform their impairments in a manner that yields something musically unique" (p. 41). If classical music is the worst culprit in his analysis of disabling musical cultures, jazz fares somewhat better, through his analyses of jazz artists with disabilities: Guitarist Django Reinhardt, pianist Horace Parlan, and vocalist Jimmy Scott. Instead of a strict adherence to notes-as-written, jazz tends to value unique, even idiosyncratic approaches. Reinhardt, missing two fingers on his left hand, would have been sunk as a classical guitarist, but in jazz became one of the most imitated and celebrated innovators on his instrument (p. 45). Parlan, a polio survivor, is not an "injured piano player", in Lubet's analysis, since he actually started studying the piano under doctor's orders as a form of physical therapy. If he had wanted to be a classical pianist, with his unimpaired left hand and only the index finger and pinky to rely on in his right hand, he would have been limited to one-hand repertoire. But in jazz he is able to play with two hands and to excel in a cultural system that values "highly original interpretation", not only through improvisation, but through composition and phrasing (p. 54).

The next two chapters are more speculative than the first two. Chapter three poses the question of '*can there be Blind Culture in the way that there is Deaf Culture?'* (p. 69), through a discussion of the Al-Nour wal Amal orchestra in Cairo, whose members are vision-impaired women musicians. Lubet describes the "protocols of learning, rehearsals, and performance" as "uniquely Blind" (p. 75). The discussion is fascinating, though this was one of the instances in which I wished the encounter could have lasted a little longer and provided more grounding in ethnomusicological research. I hope that Lubet or someone else will revisit this with the questions posed by the discussion of this orchestra that performs western classical music from memory and without a conductor. Additionally, explains Lubet, they not only perform western classical music, but a 19th century romantic repertoire in which following a conductor for "gradual shifts of tempo and dynamics" is particularly important in a sighted orchestra (p. 87).

Chapter 4 is an essay on comparative gendered restrictions on music-making in religious cultures. This is not an essay that argues and supports a point, but one that reflects on surprise as a teaching moment, and points to additional work that might be done to study fundamentalist religion, gendered musical prohibitions, and disability studies.

Perhaps of most interest to readers of *Approaches* is Lubet's final chapter, *"Bringing it all Back Home... Or Teach Your Children... Well?"*, which raises the question of "who are the Others?" in the typical school of music in a research university (using his own institution as a model) – and theorising how schools of music might benefit from reframing pedagogical approaches from a disability studies standpoint. "Who are the Others?" in my music class (music therapy practice, musical community, definition of what counts as music, etc.) is an important question to ask, always, even for those of us who think about difference and

inequalities all the time. This courageous chapter reveals Lubet's many attempts and struggles within his profession and institution to pragmatically reinvent music pedagogies that benefit from disability studies approaches.

My one disappointment with this book is that there are some bold claims about the limitations in other fields of study that are sadly not conversant with ongoing scholarship over the last thirty years that would complement and support Lubet's "social confluence theory". Poststructural, performative, intersectional, and embodied approaches are no stranger to women's and gender studies, queer theory, transgender studies, theories of race, etc. (all of which Lubet erroneously bundles as "area studies" – an entirely different group of interdisciplinary fields, centres, and departments organised originally around "areas" of the world). It would be, in fact, difficult to *find* current scholarship in gender (even transgender), sexuality, and race that support notions of "fixed identities" and strict binaries that he suggests characterise these fields (pp. 93-97, 102-103). Nevertheless, these are adjustments that can be made by readers through supplementary texts.[1] The last fifteen years have also brought a flourishing of exciting intersectional work within disability studies (sometimes known as crip theory) that incorporates feminist theory, radical feminist of colour theory, and queer theory, and, to a lesser extent transgender studies (though Eli Clare's *Exile and Pride: Disability, Queerness, and Liberation* addressed all of these intersections in 1999) and I would have been interested in how Lubet would have engaged with these works in *Music, Disability, and Society*.

It is true, however, that previous works have not addressed musical cultures within a disability studies framework, and I look forward to reading a new flourishing of work that will benefit from an overlapping of approaches incorporating those posited by Lubet read in conjunction with other current theories of how people navigate intersecting, shifting, changing multiple social fields. Lubet's book is *provocative* in that whether or not one agrees with its arguments, is on-board with the claims, or is compelled by the research from chapter to chapter, this is really not the point of this book. Taken together, or selectively, the chapters form extremely successful "think pieces". Like many highly original books, *Music, Disability, and Society* also bears some idiosyncratic twists and turns that may startle, challenge, excite, and even occasionally frustrate readers. The reader may set down the book from time to time, but the book doesn't leave the reader. I know that my thinking about disability, music, and society has been utterly rearranged in many meaningful ways as a result of reading this book.

[1] An incomplete list of pivotal works outlining these shifts would include: Anzaldúa (1990), Butler (1999), Johnson (2005), Moraga and Anzaldúa (1981), Muñoz (1999), Kosovsky Sedgwick (1990), Spelman (1988). Musicologists incorporating feminist theory and queer theory in the 1990s also were far from stuck in a 'fixed identity' as an analytic: see Brett (1994) and McClary (1991). Lubet is an important figure in the overlapping of non-essentialist, embodied perspectives of gender, race, disability, and music, but he is in very good company when it comes to eschewing "fixed identity" for approaches to social constructions and performative negotiations of social categories as simultaneous, shifting, fluid, and triggered differently from moment to moment in social interaction with one another, institutions, and discourses.

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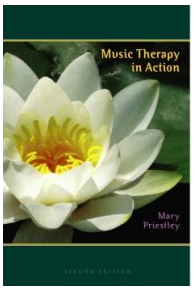
Book review

Music, Language and Autism: Exceptional Strategies for Exceptional Minds (Adam Ockelford)



Reviewed by Alex Lubet

Title: Music, Language and Autism: Exceptional Strategies for Exceptional Minds | **Author:** Adam Ockelford | **Publication year:** 2013 | **Publisher:** Jessica Kingsley Publishers | **Pages:** 272 | **ISBN:** ISBN: 978-1-84905-197-2

Alex Lubet is Morse Alumni/Graduate and Professional Distinguished Teaching Professor of Music at the University of Minnesota (USA). He is the author of *Music, Disability, and Society* (Philadelphia: Temple University Press, 2011) and dozens of articles on disability issues within and beyond music. He is the founder and head of his university's Interdisciplinary Graduate Group in Disability Studies and a past winner of the University of Minnesota Disability Services' Access Achievement Award.

Email: lubet001@umn.edu

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I begin this review by stating, in the spirit of full disclosure, that my professional background differs considerably from most who contribute to *Approaches*. I am neither a music therapist nor a specialist music educator, nor am I a clinician of any kind. I am also an American. My field relevant to this review is disability studies in music, which I am widely credited with having founded (Straus 2011) and in which I first published (Lubet 2002). Disability studies are broadly and deeply interdisciplinary, drawing principally from the humanities and social sciences and those professions with which they are often allied, such as education, counselling, and social work. Fundamental tenets of the field include approaching disability as a civil and human rights concern and self-advocacy by disabled people. While I am well-acquainted with both music therapy and Autistic Spectrum Conditions (ASC), the unusual perspectives that inform my background may mean that my review of Adam Ockelford's book may reflect biases different from most contributors to this journal.

The title of Ockelford's *Music, Language and Autism* portends a vast intersection of three vast topics. In this he certainly succeeds, taking on each topic individually and interrelating them lucidly and intelligently. Drawing upon decades of teaching children with ASC and other disabilities (including multiple disabilities), as well as a formidable career as a researcher, the book's introduction and seven chapters progress from an exposition of the manifestations of autism, through "The Challenge of Language" (p. 28) for children with ASC, the structuring of music (principally according to his "zygonic" theory), the development of musicality (which he regards as exceptionally common among children with ASC), the interrelationship of music and language in communication, "Exceptional Early Cognitive Environments" (p. 211), and a final chapter on teaching children with both exceptional musicality and ASC. I had anticipated that a greater proportion of *Music, Language and Autism* would be dedicated to the kind of pragmatics that are the focus of the final chapter. Music therapists and special music educators should bear this in mind. While this book is often extremely interesting, mostly very well written (and largely accessible to non-musicians) and includes information that may well inform practice indirectly, this is far from first

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and foremost a book of clinical and teaching techniques.

FOUNDATIONAL CONCEPTS

The *Introduction* briefly references theories of autism and synopsises key ideas that frame Ockelford's theses throughout the book. One such theory, the relationship between autism and blindness is a bit concerning. That this is a strong relationship is a rather bold claim, one whose case he makes better later, though not quite thoroughly convincingly and which would have benefited from citations of significant studies, in addition to those accounts of the author's own experience as a teacher which he provides. His personal experience looms consistently quite large throughout this text. He concludes with a useful guide to navigating the book (pp. 20-22).

The very brief Chapter 1 concerns theories of autism, the needs of many children with ASC whom he does not regard as "higher functioning" (he never calls them "lower functioning") for specialist professional support, and his case for music playing a larger role in their education. The prevailing view within disability studies in both North America and Europe favours inclusive education, which is not referenced. Inclusivity in no way precludes the engagement of professionals with training in disability and given that, as the author writes, language and behaviour can be particular challenges, an acknowledgement of the possibility of socially integrative approaches would have had value.

In Chapter 2, *The Challenge of Language,* the author is at his best. Ockelford writes with great thoroughness and eloquence of the many dimensions that contribute in an integrated manner to the meaning of linguistic utterances, spoken or written, and how these present particular challenges to children. It features a close reading of the text of *Twinkle, Twinkle, Little Star,* that highlights the difficulties a person with ASC might have interpreting its meaning. It is quite enlightening, but also implies an English-centric bias – an emphasis on particular characteristics of English, such as its approach to word order. Readers, including especially practitioners whose clients know and/or use other languages, should bear this in mind.

Early on in Chapter 2, Ockelford states "there is no evidence that autistic children's understanding of *music* [italics Ockelford's – in contrast to *language*] is impaired – in fact, quite the reverse" (p. 29). He references both a quantitative study by Rimland and Fein (1988) and his own experience to argue that at least 5% of autistic children (Rimland and Fein observe that half of the 10% in whom they detect "savant-like abilities") may have "special musical abilities" (p. 29). This is a problematic assertion in that it depends on a rather narrow definition of what is meant by "understanding" music – for Ockelford, principally a sense of absolute pitch (AP) and the ability to perform on an instrument – and the presumption that impairment and giftedness in the same endeavour must be mutually exclusive. They need not.

One needs go no further than the final Chapter 7 to read Ockelford's account of his years of attempting to teach – with only limited success – standard keyboard fingerings to his star "savant" pupil (pp. 248-250). Surely, the logic behind those fingerings is part of understanding music. The chapter and book then proceed to a discussion of whether children with autism can "feel" or can learn to feel the emotional content of music as neuro-typical people do (pp. 256-258). Ockelford is ambivalent about whether this is possible and also questions whether it matters. While I agree with him on both counts, there can be no doubt that "feeling" and "understanding" music are, at the very least, intersecting capacities. If there is an inability to "feel" music as emotion, there is thus also an inability to understand it, at least on one level fundamental to many kinds of music, including much of the Western music that grounds his theories.

In Chapter 3, *Making Sense of Music* (p. 62), Ockelford explains how music creates meaning and how this differs from linguistic expression. He is clear that music as a "language" – a common attribution – differs significantly in its communicative abilities from verbal/written language. He presents his "zygonic" theory of musical structure and sense. The theory began as an analytical paradigm for musical professionals, but he eventually realised that it "is particularly good at explaining how some children with autism may process music: indeed the theory could have been constructed with them in mind!" (pp. 66-67).

"Zygonic" theory is interesting, though I wish he'd named it something more obviously descriptive. The theory's foundation is that imitation is the root of all musical structure. To be sure, imitation as he defines it abounds in most music, but, at least here, it does not account well for, or perhaps even allow for, moments of genuine contrast. Further, zygonic theory employs dense verbal descriptions of musical phenomena, such that even the analytical example he offers, of the

melody (only) of *Twinkle, Twinkle, Little Star*, is lengthy, initially seven pages of prose and diagrams (pp. 74-81) (and he returns at considerable length to *Twinkle* later in the chapter). Based on this analysis, it is difficult to imagine the application of zygonic theory to longer works or even a harmonised, fully contrapuntal, orchestrated rendering of *Twinkle*, though Ockelford has published substantially elsewhere and considered more complex works (for example, Ockelford 2006).

The nuances of zygonic theory, though, may ultimately be less important than that, as Ockelford argues, the highly imitative structure of music, with a far higher rate of redundancy than verbal/written language, as well as music's opportunity to be appreciated on many levels, makes it highly accessible to children in general and children with ASC in particular. Music may thus facilitate language acquisition and other extra-musical learning. The chart that concludes this chapter, which describes "the key similarities between language and music" (pp. 110-113), is quite valuable.

INTEGRATION OF CONCEPTS

Chapter 4 concerns *How Musicality Develops*. Ockelford observes six stages of musical development and "three domains of engagement": "reactivity, proactivity, and interactivity" (p. 21). The last of these domains, "interactivity," is important to the distinctions Ockelford draws between music and language, in that simultaneous active participation is fundamental to the former and relatively marginal to the latter. It is here that the author introduces his *Sounds of Intent*, a framework for describing the level and nature of children's engagement with music in its three domains.

While at times Ockelford writes quite beautifully, this chapter presents difficulties. It includes pages of transcribed field observations (a total of 78) (pp. 115-123) describing how "children with learning disabilities, including autism, engag[e] with music," as well as a couple of challenging charts (the second is 3 pages long and full of abbreviations) (pp. 134-136), illustrating *Sounds of Intent* as a paradigm for evaluating musical engagement, apparently based far more on the author's (considerable) experience than upon supporting literature. The application of *Sounds of Intent* is illustrated with a case study of a client with multiple cognitive, mobility, and sensory impairments. When the case was entered as prose into the longer of the two aforementioned chart templates, it filled 12 pages (pp. 146-158).

It was at this point in my reading that I began to be concerned for what struck me as the imbalance of qualitative versus quantitative data, in both the author's own findings and those sources he (too infrequently) references, as well as the strong subjectivity of research that leans so heavily upon one person's (and to a limited extent, his close colleagues') experience. While this may reflect my North American bias, against which I cautioned readers, I would have preferred that the field notes had been coded into a few clear trends rather than served raw and, given especially that so much data appears to have been available, that the *Sounds of Intent* graph a database of cases, rather than chronicling a single case history as prose. A parallel concern for me, which likewise emerged during my reading of this chapter, was a preference for observation (of the case study) over outcomes. While "Shivan's" life appears to have been enriched aesthetically by his intensive music education, readers are never told of positive extra-musical outcomes that may or may not have emerged. Though Ockelford is apparently not a music therapist (more about such vagaries later), such outcomes might be an expectation, at least of the music therapy readership of this journal.

Chapter 5, *Music, Language, and Communication*, is concerned with the manner in which music (and sound) can be used by children with ASC to facilitate communication in a variety of ways. Ockelford emphasises the often-uneven development of music versus language, the former significantly, even spectacularly, advanced over the latter. In one case, he writes of a non-verbal student who has learned to use music performed on keyboard as a "proxy language", in which an evolving repertoire of gestures are employed with some facility as symbolic communication. How this might be useful away from the keyboard is not discussed. Other cases show music enabling speech and social interaction. In addition, Ockelford introduces *All Join In!*, a cycle of 24 original songs that he uses to facilitate communication.[1]

Chapter 6 concerns another fundamental tenet of Ockelford's praxis, *Exceptional Early Cognitive Environments* (p. 211) or EECE's. Like "zygonic", I found this terminology opaque and I remain unsure why he refers in his "new theory of autism and

[1] These songs are said to be available for free download, on the *Sounds of Intent* website: http://soundsofintent.org/index.php?option=com_content&view=article&id=10. However, this was impossible when I made the attempt, as there was no link.

music" (p. 241) to autism creating an "environment." In brief, though, the author's thesis is that children with ASC tend to process all three categories of sound as he (quite reasonably) defines them – speech, music, and "everyday sounds" – "as though they were inherently musical, and in terms of musical structure (repetition)" (p. 241). His particular interest here is in the 5% of children with ASC who exhibit exceptional musicality in the form of absolute pitch, which often leads to the early acquisition of the ability to play, largely auto-didactically, an instrument, typically a keyboard, though often with unorthodox technique that is difficult for teachers to guide toward a more standard approach. The chapter is ultimately about such talented children, frequently referred to here (to my discomfort, because of negative connotations elsewhere) as "savants". Ockelford is particularly interested in nurturing their gifts and concludes: "It is crucial that appropriate adult support be provided to guide the development of technique and a love of playing in social contexts is available as soon as possible" (p. 242).

That this and the final chapter are really about the exceptionally musical 5% of children with ASC is concerning. Even if a larger percentage of children with ASC are exceptionally musical than the percentage found in the neuro-typical population (based heavily upon the less-than-convincing measure of absolute pitch), that obviously leaves 95% of the ASC group about whom we have learned little, at least in terms of their musicality, the role of music in their lives and education, and what extra-musical benefits music might have for them. This is a disappointment for me and one that culminates in the final chapter.

APPLICATION OF CONCEPTS (TEACHING)

The title of Chapter 7, *Teaching the 1 in 20*, makes clear precisely to whom *Music, Language and Autism* refers to in its subtitle, *Exceptional Strategies for Exceptional Minds*. It is not children with ASC in general, who are "exceptional" (another discomfiting term) by virtue of the non-neuro-typicality that will likely lead to disablement in so many situations and endeavours. Rather, "exceptional" is mostly synonymous with the giftedness of the 1 in 20. The chapter thus offers no best teaching practices for those working with the 19 in 20. Those recommendations provided for the 5% are sometimes helpful. These include "*don't talk too much* (if at all)!" (italics Ockelford's) and that parents should be present for lessons whenever possible (with an admonition for those music therapists whose praxis differs) (p. 245). But the author emphatically cautions, "there are no golden rules!" (p. 245).

While readers should have every reason to accept that Ockelford is an effective and dedicated teacher, a number of his recommendations will be difficult to translate into one's own praxis. One entire paragraph of advice bears quoting in its entirety:

> And if the child does nothing? Discreetly introduce fragments of music. 'Talk' to children through pure sound. Improvise. Entice them to engage with you musically, excite them, tease them with single notes and exotic chords, a metronomic beat and quirky rhythms. Above all, be musically interesting; make your playing or singing *irresistible* (italics Ockelford's, p. 246).

At the risk of seeming harsh, what is a teacher or therapist to make of that? How does one translate that into one's own practice?

Most of the chapter concerns the student whom the author apparently regards as his greatest pedagogical accomplishment (pp. 246-258), Derek Paravicini, "a blind, autistic musical savant" (p. 217). While the young man, a pianist, is an extraordinary talent, loves music and public performance, and has had an auspicious career onstage and in major media, along with his teacher, we are told that he cannot tell which finger is which, reliably distinguish fingers from thumbs, or tell left from right (p. 251). It almost goes without saying that his fingering remains largely unconventional (p. 252).

Music, Language and Autism concludes with advice for those who teach the "exceptional":

> "Overall, the most important thing for those responsible for the education of children and young people on the autism spectrum who are (or may be) functioning at Levels 5 or 6 of the *Sounds of Intent* framework [that is, the students with the greatest musical gifts or potential], is to ensure that specialist provision is put in place as early as possible, with the aim, always, of minimising the impact of disability through maximising musical potential" (p. 259).

Again (and at the risk of seeming harsh once more), it is hard to know what to make of this. While surely young Paravicini has gained a great deal of joy out of music and public performance, the descriptions of his impairment in both this book and on the *Sounds of Intent* website (which sensationalise his accomplishments in a manner

that Disability Studies sometimes refer to as "enfreakment"), indicate that his ability to engage independently in the performance of the activities of daily living must be quite limited. His music education and performing career seem to have helped little if at all in this regard. Further, such extra-musical accomplishment, a fundamental goal of music therapy, is almost entirely unexamined in any of the case histories in *Music, Language, and Autism*.

CONCLUSIONS

This is certainly an interesting book and worth reading, but, as previously stated, of limited practical value. As a work of scholarship, drawn so deeply from the author's own experience and more likely to reference "anecdotal evidence" than large *n* studies (at least studies clearly identified accordingly, with quantitative evidence), it is more compelling than convincing. The author's biographical information is spotty on data that, had it been provided would have lent credibility. We are told that, among other things, Ockelford is a professor (where? of what?) and a composer (of anything besides the reverenced didactic works?). We are not told in what fields he was trained (which his University of Roehampton, School of Education homepage (www.roehampton.ac.uk/staff/adam-ockelford/), where he is Professor of Music, indicates that these do not include music therapy, music/special education, or psychology).

Music, Language and Autism: Exceptional Strategies for Exceptional Minds can certainly be recommended as a chronicle of the observations and praxis of an accomplished educator and researcher, with a storied career. Potential readers seeking helpful information for their clinical/teaching practices with children with ASC, or studies that build on a wide variety of clinical literature, including large *n* quantitative studies, may find that there are more useful sources.

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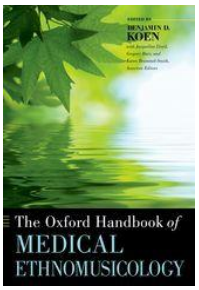
Book review

The Oxford Handbook of Medical Ethnomusicology (Benjamin Koen, Jacqueline Lloyd, Gregory Barz & Karen Brummel-Smith, Eds.)



Reviewed by Charlotte Cripps

Title: The Oxford Handbook of Medical Ethnomusicology | **Editors:** Benjamin Koen, Jacqueline Lloyd, Gregory Barz & Karen Brummel-Smith | **Publication year:** 2008 | **Publisher:** Oxford University Press | **Pages:** 556 | **ISBN:** ISBN: 978-0-19533-707-5

Charlotte Cripps began her academic career at the University of Leeds, where she studied BA Music. She continued on to an MA degree in Music for Development at the School of Oriental and African Studies (SOAS), during which she also spent several months as an intern at the Nordoff-Robbins music therapy research department, London. Charlotte currently resides in Cape Town, South Africa, where she works for a non-profit organisation that provides musical interventions to young people in marginalised communities, called *MusicWorks*.

Email: crippslottie@gmail.com

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The Oxford Handbook of Medical Ethnomusicology is the first edited volume published to outline the emergent field that is 'medical ethnomusicology'. This evolving discourse, as the introduction informs us, has been prompted by a growing *interdisciplinary* consciousness among researchers and practitioners of music, health sciences, medical humanities and healing arts.

Benjamin Koen (ethnomusicologist, professor of medical anthropology and the primary editor of the volume) foregrounds the volume in an introductory chapter alongside Gregory Barz, (ethno-musicologist and professor of musicology) and Kenneth Brummel-Smith (family physician, writer and singer). Koen, Barz and Smith identify gaps between disciplinary knowledge and research areas. For example medical anthropology tends to investigate social and bio-political aspects of illness as well as cultural and historical contexts behind medical practices, yet rarely concerns itself with the role of music and sound in healing (p.4). On the other hand, music is often considered by complementary and alternative medicines, which rarely focus on *cultural* aspects (pp.4-5). The editors subsequently suggest that in order to address these gaps, we might engage in "integrating knowledge from diverse research areas and domains of human life that are conventionally viewed as disparate but are laden with potential [health, curative, and wellbeing] benefits" (p.3).

A series of edited chapters follow the introduction, where each author contributes their own research and perspectives towards this holistic paradigm of musical health and healing. Contributing authors concern themselves with many disciplines including music, ethno-musicology, anthropology, psychology, sociology, the physical and social sciences, linguistics, theology, geriatrics, art and technology, as well as world music pedagogy. The volume aims to inspire well-rounded discourse and further research that links health care disciplines and "offers a fresh potential to sustain health and create healing" (p.14).

The editors outline three basic themes that permeate the volume's content. Firstly, "the

effectual and dynamic interrelationships between the broad domains of human life that contextualize health, healing, illness, and disease– namely, the biological, psychological, social, emotional, and spiritual domains" (p.5). The second theme is the encouragement of "collaborative, integrative, and holistic research" (p.5) that builds on new knowledge and inspires original ways to apply said knowledge in health, healing, or curative practices. Finally, the editors describe the volume to be representative of current discourses across disciplinary fields concerned with music and health, culture and medicine: A form of 'documentation' at this stage. Chapters are consistently structured, with a prelude, introduction and main text.

As a reviewer, my background includes exposure to music therapy from a researching role, as well as a postgraduate training in music for international development, which involves ethnomusicology and medical anthropology. As such, I was highly aware of the aforementioned disciplinary gaps outlined by the editors. My original exposure to music therapy was within the context of the UK, where it seems that the clinical, somewhat privatised setting could benefit from considering the performativity of cultures – both musical and otherwise – within the client-therapist relationship. I was also puzzled during my studies by how little music and sound featured in medical anthropological discourses in regard to politics and the embodiment of the senses (particularly in comparison to sight, pain and smell), I find it exciting to be around at a time where these gaps are being addressed in a collective multi-disciplinary effort, navigating towards a new field, *medical ethnomusicology*.

Some authors within this volume strive to bridge disciplinary gaps by developing analytical frameworks that acknowledge key mutual points of interest concerning how music heals across many disciplines, whilst being accommodating to various levels of context-specific variability. For instance, Koen suggests to have identified "culture-transcendent or universal principles and processes that undergird and facilitate health and healing" (p.93). One of which, for instance, being the 'human certainty principle' (HCP); namely, "the experience of *certainty* or a *knowing* that healing has occurred or is imminent" (p.95). This, he asserts, underlies "diverse practices of music or sound healing or prayer, and meditation, as well as unexplained healing transformations that occur in patients throughout the world regardless of the system of treatment" (p.95). Koen draws links between the overlapping, sometimes identical, functions of music, prayer and meditation in healing and illustrates this by alluding to a musical religious genre in the Pami Mountains region of Badakhshan, Tajikistan: namely, *maddâh,* meaning 'praise'.

A particularly interesting feature underlying the HCP principle is the deeply entrenched meaning latent in the music of *maddâh* that mobilises this certainty: specific words and passages in a *maddâh* performance "in and of themselves are believed to embody and convey the healing energy of *Baraka*" (p.105). *Baraka*, being "the spiritual energy that can heal, bless, edify and transform, is viewed as the efficacious element [of healing]" (p.104). *Baraka* "emanates from God and is found throughout creation […] It is through the internalization of *baraka* that a person can be healed" (p.104).

It seems to me a golden thread that links many of this book's chapters concerns *what is latent* in sonic stimuli that brings about the performativity of musical healing; from the micro-moments of musical interaction in clinical music therapy, to cultural, spiritual, socio-economic information that is indexed by association in sound stimuli. Koen then, strikingly illustrates how music is a carrier of symbols, shared extra-musical inferences, identity markers, and/or powerfully imbued sacred components that underlie the efficacious healing element.

Theresa A. Allison, a physician and ethnomusicologist, looks at how collaborative song writing in a nursing home cultivates behaviour, such as consensus building and sharing of "musical symbol of shared religious identity" (p.236) which "serves the co-creation of culture in any given social environment" (p.225). Similar to the efficacious healing element described in Koen's chapter, Allison unpicks in her ethnography that through musical identity markers, the home "becomes a place in which new relationships must be negotiated by its residents and a place inscribed with meaning that transcends its physical boundaries" (p.238). Thus, the efficacious healing element in music is once again via extra musical inferences, which, in this case, mobilises renegotiation of institutionalised environment towards a health-sustaining community life.

Marina Roseman accounts for the theme of extra-musical referencing in her 'Fourfold Framework' for musical healing. She illustrates moments of musical healing to be simultaneously situated on *musical*, *sociocultural*, *performative* and *biomedical* axes. Whilst the musical axis concerns music's ability to trace emotions in motion, the sociocultural pertains to the "cognitively inherent or

socially learned patterns of sensory excitation (and/or anesthetization) incumbent within culturally specific designs of musicking and dancing" (p.29). The performative axis refers to the "…imaginary journeys taken as we listen to performances" (p.29). Finally, Roseman describes the biomedical axis to be the transformation from illness to health on a neurophysiological or psychobiological level. She gives an in depth depiction of the Temiar music healing ceremony by means of example, whereby a patient diagnosed with the illness of displaced soul energy may then find and resituate lost soul components.

However, an occupational hazard involved with investigating healing ritual processes using a multi-disciplinary framework is that analytical techniques and research agendas are *not* always confluent. One conflict in the volume occurs in a recurrent suggestion that bodily changes should be measured as a means of understanding "mechanisms of music's effects on physiological outcomes" (p.437) and therefore validating, even potentially quantifying that an impact is being made. This conflicts with the anthropological priority to take seriously cultural practices and frameworks of assessing health on their own terms. As Roseman comments

> "[to] translate the language of ritual healing, spirituality, and musicality into biomedical terms […] might appear to devalue the integrity of the original terms" (p.35), "denying[…] indigenous epistemologies of healing by implying that they are invalid unless they can 'prove' themselves before the altar of conventional biomedical epistemology" (p.35).

She then however comments that on another level, something is gained in translation that honours the indigenous practice, including a wider audience. However, if the aim of medical ethnomusicology is to truly gain "a deeper understanding of music's potential power to promote health or healing within diverse cultural and clinical contexts, multiple ontologies, epistemologies, and methodologies" (p.13), we must focus on innovative experimental methodologies and cross-cultural frameworks of comparison that take seriously the understandings of healing from which these practices are borne. This would surely better suit our cause, rather than shoe horning a measure onto the unwilling subject that analyses a different intention and result, for the purpose of mediating a more palatable version of our findings for a lay man western audience, who we are assuming here to not be open minded enough to see past their own doctrines. Therese West and Gail Ironson also aptly point out that even were assessments of physiological change relevant, they run the risk of wrongly attributing a physiological change to an aspect of healing. There is a "tendency to oversimplify the relationships among music-mind-body interactions, which leads to the selection of a physiological marker without fully understanding the relevance and limits of that marker" (p.424).

This said, West and Gail then go on to justify the need for objective outcome evidence and suggest *psychoneuroimmunology* (PNI) to bridge this gap: namely, the study of "the dynamic, complex, and multidirectional interactions among psychological, neurological, endocrine, and immunological systems" (p.424). Once again, this opens up the need for further discussion in regards to the objectives of medical ethnomusicology: Who is inquiring into whose health practices, with whose baseline understandings of health, and for whom? The editors comment in the introduction, "[d]espite this rapid growth of interest, there is not – nor could there be – a unified theory for medical ethno-musicology at this time, except at the broadest level that we have identified in our central themes" (p.15). Perhaps then, our next primary concern when engaging in further discussions should be to clarify baseline principles and priorities in regards to medical ethnomusicology, as opposed to sitting on the fence by using physiological measures with an asterisked disclaimer.

In terms of the contributing authors, many do not explicitly introduce their professional backgrounds at the beginning of the chapters. Having this information consistently stated might be useful for the reader in terms of mapping disciplinary confluences more explicitly, yet it may be that this was avoided in fear of sectioning off disciplinary trains of thought. Throughout the volume, the reader is also presented with the task of familiarising themselves with the styles of writing in each chapter, which inevitably varies. Roseman comments that specialised language, with insider terms and concepts could potentially limit our collaborations should we not learn each other's disciplinary terminologies, or use 'opaque' enough language to be accessible to other disciplines and it is with this in mind that medical ethnomusicologists ought to be cautious not to develop a new inaccessible linguistic silo, or set of 'suitcase' words as the conversation develops.

Given the myriad of material covered in the volume's 556 pages – expressed using various disciplinary languages and jargon – this volume would benefit from a final chapter containing

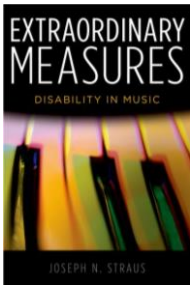
concluding thoughts that recapitulate the three themes outlined in the introduction, now with some of the chapter details. This would assist the reader in navigating their way through a vast volume of information and stimulating – yet sometimes potentially conflicting – concepts. This said, the volume succeeds fantastically in its aim to shine light on disciplinary gaps and to provide a stimulus for "ongoing conversations and ongoing engagement of the integration necessary for an appropriate subject of inquiry to be constituted and grounded in collaborative studies between music and medicine" (p.15) It is now the job of musicians, health workers, physical and social scientists, medics, medical anthropologists, sociologists, and practitioners of complementary medicine and the healing arts alike, to follow through these conversations that might move towards a more open-minded, holistic and in depth understanding of health, healing and cure.

Suggested citation:

Cripps, C. (2017). Book review: "The Oxford Handbook of Medical Ethnomusicology" (Benjamin Koen, Jacqueline Lloyd, Gregory Barz & Karen Brummel-Smith, Eds.). *Approaches: An Interdisciplinary Journal of Music Therapy, 9*(1), 142-145.

Βιβλιοκριτική

Extraordinary Measures: Disability in Music (Joseph N. Straus)



Από τον Αλέξανδρο Χαρκιολάκη

Τίτλος: Extraordinary Measures: Disability in Music | **Συγγραφέας:** Joseph N. Straus | **Έτος:** 2011| **Εκδόσεις:** Oxford University Press | **Σελίδες:** 224 | **ISBN:** 978-0-199766-45-1

Ο **Αλέξανδρος Χαρκιολάκης** είναι Διευθυντής της Μουσικής Βιβλιοθήκης Erol Ucer και Λέκτορας στο MIAM – Istanbul Technical University. Σπούδασε στο Ελληνικό Ωδείο πιάνο και θεωρητικά και κατόπιν μουσικολογία στο University of Sheffield απ' όπου αποφοίτησε με BMus και MMus. Στο παρελθόν έχει εργαστεί στη Μεγάλη Μουσική Βιβλιοθήκη της Ελλάδος "Λίλιαν Βουδούρη" ως υπεύθυνος των εκπαιδευτικών της προγραμμάτων.

Email: a.charkiolakis@gmail.com

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Ο συγγραφέας εκκινεί την ερευνητική του διαδρομή από μια προσωπική ιστορία, που περιλαμβάνεται στις πρώτες σελίδες του βιβλίου. Εκεί, αναφέρεται για πρώτη φορά στον όρο 'disability studies', τον οποίο χρησιμοποιεί μια συνάδελφός του. Η συζήτηση περί του συγκεκριμένου ερευνητικού αντικειμένου προκύπτει από την ανάγνωση ενός βιβλίου για τον αυτισμό, με το οποίο ο Straus καταπιάνεται από καθαρά προσωπικό ενδιαφέρον, καθώς ο μεγαλύτερος γιος του έχει αυτισμό. Μετά από αυτή τη συζήτηση, ο συγγραφέας αποφασίζει να ξεκινήσει την ενασχόλησή του με το εν λόγω αντικείμενο. Το βιβλίο αυτό είναι λοιπόν ο καρπός της ερευνητικής του δραστηριότητας από το 2002 μέχρι σήμερα. Το συγκεκριμένο πόνημα λειτούργησε κι ως αφορμή για μια σειρά δημοσιεύσεων στον χώρο της μουσικοθεραπείας, όπως οι ακόλουθες: "Voices from the ghetto: Music therapy perspectives on disability and music (a response to Joseph Straus' book 'Extraordinary measures: Disability in music')" (Tsiris 2013) και "Music... to cure or disable: Therapy for whom?" (Honisch 2014). Μάλιστα, το τελευταίο άρθρο δημοσιεύθηκε σε ένα ειδικό τεύχος σχετικά με το θέμα, κι ένα από τα άρθρα είναι από τον ίδιο τον Straus.

Ο Straus είναι γνωστός μουσικολόγος, ειδικός στη συστηματική μουσικολογία και πρώην πρόεδρος του Society for Music Theory. Εκ πρώτης όψεως λοιπόν θα φανταζόταν κανείς ότι η θεματολογία του συγκεκριμένου βιβλίου βρίσκεται μακριά από το αντικείμενό του. Παρόλα αυτά, στο βιβλίο ο συγγραφέας καταπιάνεται με σειρά ζητημάτων που ξεπερνούν τις συνήθεις αντιλήψεις για την αναπηρία (ή για αυτό που πολλοί εκλαμβάνουν ως αναπηρία), η οποία ιατρικά προσδιορίζεται διαφορετικά από την εικόνα που καλλιεργούμε γι' αυτήν στην καθημερινότητά μας. Ως αναπηρία ο Straus καταγράφει όλες εκείνες τις καταστάσεις που λειτουργούν αναπόδραστα και μοιραία (είτε προσωρινά είτε μόνιμα) στη ζωή ενός ανθρώπου και την αλλάζουν, με συνέπεια ο ίδιος να μην μπορεί να ανταποκριθεί σε καθημερινές συνήθειες στις οποίες μέχρι πρότινος μπορούσε να αντεπεξέλθει.

Το βιβλίο εκτείνεται σε οχτώ κεφάλαια, όπου παρουσιάζονται αρκετές πτυχές του θέματος: από απολύτως πρακτικές αναφορές που αφορούν τις φυσικές αναπηρίες συνθετών (απώλεια ακοής, προβλήματα κίνησης κ.ά.) μέχρι και τη μουσική απόδοση της αναπηρίας σε διάφορα έργα γνωστών συνθετών. Έχει αρκετό ενδιαφέρον το γεγονός ότι ο συγγραφέας προσδιορίζει όλων των ειδών τις ειδικές συνθήκες που μπορεί να συντρέχουν κατά

τη διάρκεια της ζωής ενός συνθέτη, συμπεριλαμβανομένων και των ψυχικών ασθενειών.

Μετά από τον απαραίτητο προσδιορισμό της αναπηρίας και τη γενικότερη σχέση της με τον κόσμο της μουσικής, ο συνθέτης ξετυλίγει το νήμα της σκέψης του μέσα από προφανείς συσχετισμούς: Καταπιάνεται με συνθέτες που υπέφεραν από διαφορετικές αναπηρίες και εξετάζει την αποδοχή που απολαμβάνει (ή δεν απολαμβάνει) η μουσική τους. Στο βιβλίο γίνεται λόγος για συνθέτες όπως ο Delius (απώλεια της όρασης), ο Schumann (φρενοβλάβεια), ο Smetana και φυσικά ο Beethoven (απώλεια της ακοής). Ο τελευταίος μάλιστα, θα υπάρξει και αντικείμενο μελέτης ξεχωριστού κεφαλαίου, του δεύτερου, όπου εξετάζονται όλες οι πτυχές της απώλειας της ακοής του και αναφέρονται ταέργα του συνθέτη στα οποία – κατά τον συγγραφέα – εμφαίνονται τόσο οι δυσκολίες του Beethoven όσο και οι τρόποι με τους οποίους ο ίδιος κατάφερε να τις ξεπεράσει. Η καταγραφή συγκεκριμένων τονικών φαινομένων και οι εξαιρετικές λύσεις που βρίσκει ο Beethoven αφενός 'προδίδουν' τη σχέση του Straus με την ανάλυση και αφετέρου αναδεικνύουν ένα ενδιαφέρον πάντρεμα δύο φαινομενικά διαφορετικών κόσμων: του πεδίου της θεωρίας της μουσικής και του πεδίου των ερευνών για την αναπηρία (disability studies). Η τελευταία, είναι μια ομολογουμένως ενδιαφέρουσα προσέγγιση που αξίζει να διερευνηθεί περαιτέρω και πιο διεξοδικά.

Στο επόμενο κεφάλαιο γίνεται λόγος για τη μουσική του Schubert και για τον τρόπο με τον οποίο αποτυπώνεται σε αυτήνη εικόνα της «αναπηρίας» του συνθέτη που έπασχε από σύφιλη. Σε αντίθεση με τον Beethoven, εδώ ο συγγραφέας χρησιμοποιεί το επιχείρημα ότι ο συνθέτης εγκολπώνει την αναπηρία του και δεν την ξεπερνά. Ο Schubert κάνει μέρος της πραγματικότητάς του την περιπέτεια της υγείας του και τα απότοκά της. Ο Straus χρησιμοποιεί ως μέρος του επιχειρήματός του τη *Σονάτα για Πιάνο D. 960* και το *Τρίο για Πιάνο D. 898* για να καταδείξει με ποιον τρόπο ο συνθέτης κάνει κομμάτι του έργου του την κατάστασή του. Μάλιστα, προχωρά κι ένα βήμα παρακάτω και παραθέτει την άποψη της κριτικής για τα συγκεκριμένα έργα και το πως αντιλαμβάνονται οι κριτικοί τα τονικά προβλήματα.

Ο προβληματισμός του συγγραφέα δεν μένει εκεί κι αγγίζει ακόμη πιο περίπλοκες συνθήκες, όπως είναι αυτές που διαμορφώνονται στη μουσική των Schoenberg και Webern. Χρησιμοποιεί τον όρο «ελεύθερη ατονική μουσική» για τα έργα στα οποία αναφέρεται (*Μπαγκατέλα op. 9 no.5* και το δεύτερο από τα *Movements op.5* για κουαρτέτο εγχόρδων του Webern, και "Valse de Chopin"από το *Pierrot Lunaire* του Schoenberg), και αναδεικνύει τα προβλήματα συμμετρίας που έχουν επισημανθεί κι από άλλους. Φυσικά, ο Straus προσεγγίζει αυτά τα προβλήματα συμμετρίας από εντελώς διαφορετική σκοπιά και προτάσσει ως αίτιο και αιτιατό τις ιστορικές συνθήκες (Α΄ Παγκόσμιος Πόλεμος) και την ευρεία δυσμορφική εικόνα της καθημερινότητας, η οποία άλλαξει τον οπτικό χάρτη των ανθρώπων της εποχής. Αναφέρεται δηλαδή στην καθημερινή εικόνα ανθρώπων που πάσχουν από σειρά δυσμορφιών, αναπηριών κ.λπ., όπως αυτές διαμορφώθηκαν από τις συνθήκες ζωής της εποχής. Σίγουρα πρόκειται για μία ενδιαφέρουσα προσέγγιση που εμπεριέχει υποκειμενικότητα, αλλά ταυτόχρονα στηρίζεται και σε αρκετά πειστικά επιχειρήματα. Παράλληλα όμως, είναι σημαντικό να αναφέρουμε ότι κι άλλοι έχουν ασχοληθεί με τα έργα αυτά επισημαίνοντας ζητήματα συμμετρίας, τα οποία αποδίδουν κυρίως στο υπό διαμόρφωση συνθετικό στυλ των εν λόγω συνθετών.

Το πέμπτο κεφάλαιο ξεκινά με μια ενδιαφέρουσα παραδοχή του συγγραφέα: «Εφόσον ζήσουμε αρκετά, όλοι μας θα καταστούμε ανάπηροι κάποια στιγμή» (σ. 82). Αυτή άλλωστε είναι και η αρχική του θέση περί του ζητήματος. Σε αυτό το μέρος του βιβλίου ο συγγραφέας μιλάει για τις μουσικές αφηγήσεις των Schoenberg, Stravinsky, Bartok και Copland, τις οποίες ο ίδιος βλέπει ως περιγραφικές της δυσμορφίας που προκαλείται από καταστάσεις κατάγματος και συντριπτικών δυσμορφιών. Το βασικό επιχείρημα του συγγραφέα είναι ότι κάποια από τα τελευταία έργα των συνθετών περιγράφουν αυτήν την αναπόφευκτη κατάσταση που επιβάλλεται στο σώμα από την ηλικία και τις συνθήκες γήρανσης. Τα επιχειρήματα που χρησιμοποιεί ο Straus δεν γίνεται να περάσουν απαρατήρητα. Είναι φυσικά δύσκολο να αποτυπωθούν σε μερικές γραμμές βιβλιοκριτικής, αλλά κατά κύριο λόγο εδράζονται κυρίως στη νοσταλγία για τη χαμένη ζωτικότητα, στη ζωή που αφήνει τα σημάδιά της στο σώμα και στο μυαλό (κατ' επέκταση και στο έργο) των δημιουργών και γενικά στην αίσθηση ματαίωσης που επιβάλλει η προχωρημένη ηλικία.

Τα επόμενα τρία κεφάλαια καταπιάνονται κυρίως με το θεωρητικό υπόβαθρο που διέπει το ζήτημα (με άλλα λόγια την εφαρμογή των αρχών και μεθοδολογιών των disability studies στη μουσική) καθώς και με ζητήματα που άπτονται των φυσικών δυνατοτήτων (και των περιορισμών τους), όπως αυτές απαντώνται σε μουσικούς εκτελεστές. Επίσης, υπάρχει ειδική αναφορά στο ζήτημα της ακοής και των υπερβολικών ή περιορισμένων δυνατοτήτων που μπορεί κάποιος να έχει.

Προσωπική άποψή μου είναι ότι το έκτο κεφάλαιο με τίτλο *Disability Within Music – Theoretical Traditions* θα έπρεπε να προηγείται πολλών που έχουν ήδη αναφερθεί, καθώς θα βοηθούσε τον αναγνώστη να έχει μια πιο σφαιρική αντίληψη των ειδικών ζητημάτων και των παραδοχών που κάνει ο συγγραφέας. Με άλλα λόγια, θα παρείχε το απαραίτητο υπόβαθρο για να προσδιοριστούν οι αφετηρίες (γιατί είναι πολλές κι όχι μία) του συγγραφέα.

Συνοψίζοντας, θα έλεγα ότι πρόκειται για ένα εξαιρετικά ενδιαφέρον βιβλίο που θέτει αισθητικά και θεωρητικά ζητήματα – κάποια γνωστά κάποια όχι – σε νέα βάση. Ο συγγραφέας δεν στερείται επιχειρημάτων, και είναι δυνατόν να πείσει ακόμη και έναν δύσπιστο αναγνώστη που προσεγγίζει με αρκετή επιφύλαξη το πόνημα του Straus. Αρκεί ο αναγνώστης να μην είναι περιχαρακωμένος στο αντικείμενό του. Το παρελθόν και το αδιαμφισβήτητο κύρος του συγγραφέα στη συστηματική μουσικολογία και στη θεωρία της μουσικής σίγουρα διευρύνει την επιχειρηματολογία του. Ο Straus εισάγει με τον δικό του τρόπο τη μουσικολογική θεώρηση στο πεδίο των σπουδών για την αναπηρία αναδεικνύοντας έναν άλλο τρόπο με τον οποίο αυτές αποτυπώνονται μουσικά. Ίσως μια νέα πραγματικότητα να ανοίγεται μπροστά μας, και μια νέα ερευνητική περιπέτεια υπό αυτό το πρίσμα να βρίσκεται υπό εκκόλαψη.

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Προτεινόμενηπαραπομπή:

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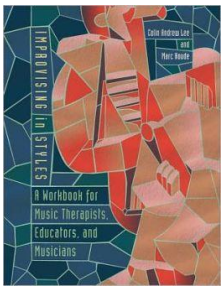
Book review

Improvising in Styles: A Workbook for Music Therapists, Educators and Musicians (Colin Lee & Marc Houde)



Reviewed by Ben Saul

Title: Improvising in Styles: A Workbook for Music Therapists, Educators and Musicians | **Authors:** Colin Lee & Marc Houde | **Publication year:** 2010 | **Publisher:** Barcelona Publishers | **Pages:** 432 | **ISBN:** ISBN: 978-1-891278-58-7

Ben Saul is a practising music therapist currently working as a clinician in specialist services for children and young people with learning disabilities and in elder care. He is also a senior lecturer in music therapy at the University of the West of England and a teaching professor in music therapy at the Guildhall School of Music & Drama.

Email: bensaul@mac.com

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> Our age seeks many things. What it has found, however, is above all: *comfort*. Comfort, with all its implications, intrudes even into the world of ideas and makes us far more content than we should ever be.
>
> Arnold Schoenberg,
> Preface to the first edition, Theory of Harmony (1911)

INTRODUCTION

First there was Schoenberg, who with others both allied and independent embarked on a compositional journey that illuminated the unfolding and invigoration of all music in the subsequent decades of the twentieth century. In laying out his theory of harmony he noted that "the evolution of no other art is so greatly encumbered by its teachers as is that of music" (Schoenberg 1922: 7). Schoenberg (1922: 1) insisted that his theory of harmony was "learned from my pupils".

Then there was the great American composer, Aaron Copland, who complained that a "regrettable gulf separates the interpreter and composer in present-day musical life. They are not interacting enough!" (Copland 1952: 57).

Also there was the pioneering music therapist, Paul Nordoff, who when he first observed the transformative effect of music therapy later told Clive Robbins

> "Here I am in Europe with a trunk full of music trying to get a symphony performed and here is a musician using music to bring a child into speech. There is no doubt in my mind which is the more important" (Robbins 2005: 8).

The warmth of the teacher-student relationship between the authors Colin Andrew Lee and Marc Houde is palpable on reading *Improvising in Styles*. Relationships between the past and the present, personal experience and abstract truth, and individual exploration and vigorous debate in community are the starting points for this publication of theirs. It is in this spirit that they have sought to bring a learning and teaching resource to music therapists, educators and other interested musicians.

Improvising in styles has been developed out of what Lee describes as a "music centred theory" of music therapy that he calls aesthetic music therapy (AeMT) (p. 6). In declaring himself a composer / therapist Lee wonders (p. 7) "What does it mean to think of clients as composers and artists? The client

as composer then becomes the blank page of the therapeutic process. This is the essence of AeMT". Does this supposition bear scrutiny? Does that not make the client the manuscript? What value can be derived from the teachings of aesthetic music therapy and how are they practically presented?

I teach music making and improvised composition to trainee music therapists. The reader can rest assured that I acknowledge the following as I begin this review.

Firstly, that I recognise the type of Damascene experience attributed to Nordoff, as it occurred to me as a young man that something such as music therapy was possible and made a better fit to my musical skills than anything else I had encountered previously in music making.

Secondly, that I recognise the importance of being both well instructed and clearly shown how to make music, where all of my music and music therapy teachers – be they in the room alongside me, on the page, on stage or in my headphones – have helped me to construct the coracle that contains my life as a musician as I go along. Coracles are ancient containers, designed over time by master craftsmen to meet a specific purpose but are also notoriously hard to propel and difficult to steer without being shown how.

Thirdly, that I have sat in many sessions where I must share the composer and interpreter role interacting with others who have better incentive to be urgent and challenging in expressing their vitality and discomfort than I, be they clients or students.

Arnold Schoenberg, armed with knowledge of the serial techniques developed by Bach, Mozart and Beethoven, grappled with the nature of and indeed the need for order in his music. I feel keenly the challenge and the compulsion of his desire that educators teach through amending their own errors, critically examining their instructions to students and seeking to improve their formulation.

It is in this spirit that I seek to offer a review and criticism of *Improvising in Styles*.

A ROAD TEST

Being able to measure the value of *Improvising in Styles* by attempting to teach with it, I am grateful to the music therapy students at the Guildhall School of Music and Drama and the University of the West of England who allowed me to do just that. Four musicianship groups of differing abilities and musical backgrounds were given sessions that focused on elements of the chapters on Classical, 20th Century and Song. Lee and Houde note that "if you are a nonpianist, it is assumed that you have mastered all major and minor scales along with all triads and their inversions" (p. 8). In the UK, this would decidedly place you in the group 'pianists' and combined with the standard of musical examples given, this book would be most accessible to players of a standard Associated Board of the Royal Schools of Music Grade VI and above.

The first thing noticed by all of the students were the errors that present themselves in the book, both in notation and description. There are six volumes of Bartok's *Mikrokosmos,* neither Domenica nor Domenico Alberti created the Alberti bass, and describing A.D. 1000-1200 as the end of the medieval period caused a great distraction and mild confusion. The two chord misspellings in the description of the Stravinsky quote from the *Harbingers of Spring* (that is an E flat 7 chord and an F flat major chord – picky, but important in the context of Stravinsky's intention) is a significant error. The transcription of the *Tiny Dancer* groove that is in a different key to John's masterpiece and then bears no relation to the motives he plays within the harmonies represents the worse sin. The description of this groove as 3+3+2 is wrong, where it actually is a great example of a groove in common time that pushes onto the third beat.

If you wanted to study this groove you would discover a neatly crafted three-part motif of stepwise descending melody, inner ascending broken chord and I to IV lilting bass. You could describe this as 3+2+3 perhaps, but then listen to Bartok's version of this feel, *No. 4* of *Six Dances in Bulgarian Rhythms*, *Mikrokosmos 151, Vol. VI*, and there is a distinct difference between this and a piece that pushes against the 4/4 straight eights John's band provide.

These examples of inaccuracies are a selection, not the totality, but once the students had got past these and moved into the exercises some work began. There are exercises on how to work bi-tonally by limiting each hand to different note rows, how to continue in a style using alberti bass, harmonic accompaniment of embellished melodies, scale and arpeggio, and fixed intervals, to give some examples. These were taken up with gusto. It was reported back that such devices had been stimulating and had encouraged students to generate material outside of where their ideas and hands would normally fall.

However, as teacher and students, we found the connecting of the often good practical music-making exercises to special claims for composers and eras unhelpful as these prefaces were often

sparse, contentious, simplistic or gnomic. At the worst, in the absence of applicable instruction students are asked to consider indigestible statements such as the following:

> "When analyzing his music for distillation into therapy, you get a sense that each phrase is concentrated and a pure outpouring of his soul. Finzi's emotional and highly crafted music should be treated with great care in the clinical setting. Like JS Bach, Finzi can cut through to a client's musical consciousness" (p. 171).

I do not know what this statement gives the student other than a confirmation that Lee or Houde have a high regard for the agnostic British composer. As a teacher I can do nothing with such highly personalised and subjective descriptions and would not begin to consider such blithe supposing with students.

Lee and Houde present a short section on the music of Gerald Finzi as part of a chapter on 20th century music, where they maintain that nationalism was a primary and defining musical framework of that period. My own personal love of Finzi's music could indeed be a departure point in preparing teaching materials for students based on his compositions. However, I would be keen to show the specifics of his use of transformations in tempo, texture and tonality and the timbral effects of pitch combinations, exemplified in works such as *Dies Natalis* and *In Terra Pax*. These devices and transformations are comparable with those found in the works of his friends Ralph Vaughan Williams, Gustav Holst, Edmund Rubbra and others. All of these composers did not so much capture Britishness but happened to share elements of musical language drawn from close friendships with each other, rivalries with other composers and an objective study of sources as varied as Tudor choral and instrumental music and English folk music, the compositions of French impressionists, European Romantic composers, and the ubiquitous Bach. Their output could now be broadly described as English romanticism. However, thinking of them as nationalistically British and that the first half of the 20th century was any more culturally preoccupied with national identity and folk traditions than any other period is not useful.

Lee and Houde reproduce whole works by Debussy and Mozart, harmonic sketches of Beethoven sonatas and large hunks of Brahms, Schumann, Bach et al. but they do not often make sure that there are tangible elements identified that we the learners can cut and propagate. Instead we are instructed too often to "focus on the beauty of this piece" or "become lost in the beauty of its sounds and textures" (p. 119). Students tended to be nonplussed by such invitations where there was little or inconsistent structure offered for them to begin to do this.

THE CASE FOR TEACHING IMPROVISING IN STYLES

When presenting music that is personally important to you, it is harder perhaps to break up such an integrated experience with its attachments and dynamics back into the elements that you suppose made them. If this is possible, you then have to experiment with language to find a way of saying what you mean in a way that can be understood by diverse audiences. As a teacher, I can quite often assume a level of understanding and shared appreciation with students at the beginning of a teaching opportunity that actually undermines the way in which the topic might be taught. Similar assumptions can compromise the way in which teachings are offered in books such as this outside of the sphere of influence of a specialist classroom or training. Such environments, where there are supportive direct relationships, always offer the opportunity to say something, repeat it, discuss it and transform it so bespoke learning takes place.

We encourage music therapy students to begin to organise continuums between sensing and thinking, particularly in their music and clinic work, as they train. Educators in music therapy should offer opportunities to enhance this with attendant focus on manageable development using stimulation based in rigorous and tested methods: not solely presenting technical methods of generating material, of course, but also not swamping the student with emotive swells. This sort of balance is more present particularly in the chapters on Jazz and the Blues, which are the stand-out lessons of *Improvising in Styles*. Overall though, across the book this balance is skewed towards enthusiastic ebullience, and learning opportunities are confounded through attempting to present music, composition and improvisation held in style, the satisfaction of self-expression and subjective receptive aesthetic appreciation. I would suggest that form and structure are the containers actually needed.

As an example, any study of the *Brahms Op. 118, No. 2,* can teach us particular things about movement within and away from the hierarchies of home key, balance of multiple voices across the hands at the piano, forms within forms,

accommodation of movement and maintenance of shape and flow in a piece of broadly ternary form that also widens or jags open in each section based on varied binary forms, dependent on your view. In one of the many student analyses of this work online, Cumberbatch (1999) notes the principle of developing variation Brahms adopts, which he uses "not only to expand musical structures and ideas, but also to interrupt and subvert normative progressions and figurations" (para 5, line 1). The ideas of developing variation and the power of internal subversions are interesting for the music therapist. These can be presented to music therapy students as a fantastic device for shaping improvisations and understanding the flow of sessions. Brahms was meticulous in his description of how he thinks the music should move and flow in these microcosm forms. Of note in this review, his student, Gustav Jenner, recalled particularly that Brahms was interested in "the spirit, not the schema" of established forms (Frisch 1984: 34 as cited in Cumberbatch 1999).

There is great value in considering what the music therapist Sandra Brown (1999) notes on the value of thinking about the detail of emotional experiences in performance and therapy framed in *calando, un poco animato, più lento* and similar transformative indicators. She suggests that these show the signs of growth and vitality that can be developed in the music therapy relationship (Brown 1999: 65). Lee and Houde's statements "[i]t is the richness of the harmonies that make the music so powerful" and "[t]his music should be played with rubato and great feeling" (p. 146) frustrate both Brahms and Brown as they in turn dilute and contradict what is evident in the manuscript and give the student no foothold to start exploring this music. Furthermore, they dispute Brown's summary of Nordoff's legacy and, in my opinion, the spirit of where the music therapy relationship should be or get to where the client, not the therapist should "take responsibility for form and structure" (p. 66).

CONCLUSIONS

Analysts such as Cook and Epstein note that style grows out of form and the stylistic clarity of the Classical and Romantic periods occurred because "form was important to the classical composers and that their style was largely designed to delineate form clearly" (Cook 1987: 14). Understanding Schoenberg to be composing using motives, motivic form and developing variations (Epstein 1987: 19) allows the student to learn about atonality in the same way they might learn about Bach, Mozart or any other composer from any other period by studying the relationships between musical elements these composers developed. The fundamental problem of the book being reviewed is that this is often disregarded, for example, where Lee and Houde state the following:

> "Atonality without form is meaningless and thus will provide a meaningless therapeutic process. Used carefully and with consideration, atonal improvisation can be a wonderful therapeutic / musical tool. Used without thought, it can be unsettling and intimidating" (p. 199).

Using any musical device, from a cadence to a sonata form without thought will potentially be unsettling and intimidating. Understanding the nature and effect of atonality should be based on clear, detailed musical thinking and not generalisations.

It would be useful to be clear that my feeling is the ideas underpinning aesthetic music therapy are limited in their ability to help develop imitable effective music therapy work. There may exist for the authors a clinically useful relationship between performing musician and clinician as practising music therapists. Many music therapists will think hard about the balance between these two parts of their lives and their effect on each other. Indeed, movement towards a clearer explanation for how music is therapeutically effective, based on what we know as performing musicians, analysts and students of the history of musical development is needed. Too often this book does not achieve this. The challenge to produce such a text may remain unmet. Speaking of what we gain from our knowledge of the history of music, Stravinsky said

> "How shall we reasonably explain what no one has ever witnessed? If we take reason alone as a guide in this field, it will lead us straight to falsehoods, for it will no longer be enlightened by instinct. Instinct is infallible. If it leads us astray, it is no longer instinct" (Stravinsky 1947: 25).

Where instinct is integrated with reason and the student is invited to consider both the mechanics and dynamics of compositions, rather than perhaps attempting to introject whole entire objects, perhaps any piece of music from any tradition can potentially teach us much about both the movements and the essences of music making that we can use as music therapists. It is incumbent upon educators in this field to show us how to grasp the nettle and then begin.

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Conference report

The Second BAMT Conference

'Re-visioning our voice: Resourcing music therapy for contemporary needs'

Claire McCarthy

The Second BAMT Conference
'Re-visioning our voice: Resourcing music therapy for contemporary needs'

8-10 April 2016

University of Strathclyde, Glasgow, UK

Claire McCarthy trained as a music therapist at Queen Margaret University, Edinburgh and qualified in 2012. She is employed by NHS Lothian and works full-time in a range of settings including education, child and adolescent mental health, adult mental health and forensic psychiatry. Claire is a flautist and singer and performs regularly in Edinburgh as part of a nine-piece soul and funk band.

Email: Claire.McCarthy@nhslothian.scot.nhs.uk

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INTRODUCTION

More than 300 music therapists, trainees and other professionals from the UK, Europe and the rest of the world attended the second conference of the British Association for Music Therapy (BAMT), which took place in the University of Strathclyde, Glasgow in April 2016.[1]

The weekend commenced with a Civic Welcome reception at the City Chambers in Glasgow. Piped in by music therapist, Rory Campbell, and formally welcomed by the Lord Provost of Glasgow, music therapists were received in opulent surroundings to drink fine wine as well as enjoy music by two music therapy students from Queen Margaret University, Edinburgh. The Chair of BAMT Trustees, Ben Saul, then continued the celebration of getting together, leading the music and dancing late into the night in the Student Union, with music therapists joining in the jam.

PLENARY SESSIONS

The plenary session speakers highlighted the need for music therapists to innovate, improvise and collaborate. Music therapists were encouraged to engage in skill sharing and partnership while still remaining confident in our specialism and individual expertise. The plenary sessions were followed by a 'talkshop' which allowed many voices from a variety

[1] For the conference proceedings, see Aravinth, Pavlicevic and Watts (2016).

Photo 1: Music therapy students from Queen Margaret University, Edinburgh provided perfect accompaniment to the evening with background jazz music: Jeremy Devlin-Thorp and Meg Dowling

Photo 2: Welcoming music therapists to Glasgow at the splendid City Chambers

of Trusts, third sector and freelance therapists to be heard. Isolation in practice emerged as an important theme. It is clear that collectively we are facing change in the health and social care landscape and that there is a need to share our expertise and experience across organisations and countries. Discussion commenced with therapists beginning to express ambitious and strategic ideas about lobbying government and informing policy. Ben Saul acknowledged the need for BAMT to take a steering role in such strategies and to support therapists across the UK to become involved in strategic groups.

Lang may yer lum reek! (Lit. Long may your chimney smoke!) Music therapy in a changing landscape (Kate Pestell and Emma MacLean)

Kate Pestell (Head of Arts Therapies, NHS Lothian) and Emma MacLean (Lead Music Therapist, NHS Lothian) opened the dialogue on Saturday morning to outline the opportunities and challenges ahead for arts therapists considering both the changing landscape in the healthcare system in Scotland and the changing needs of the population. Among the questions posed was how do we hold on to our professional identity and unique contribution at a time when limited funding may put us in competition with our colleagues in arts in health? Particular emphasis was placed on partnership working to develop a continuum of music and arts in health and social care. They encouraged us to be outward facing, by developing partnerships with other agencies, finding strength in the affiliate disciplines of the arts therapies and further defining our roles *within* our professional workforce.

The speakers asked the audience to consider a definition and how well it communicates to commissioners the need, justification and effectiveness of our brand of therapy. Issues around evidencing effectiveness, and use of appropriate methods of measuring outcomes and evaluating patient experience were discussed between the clinician and the service manager. The subsequent conference buzz highlighted concerns around delivering a service that was both 'high quality' and 'low cost' and questioned where and how the freelance music therapist might fit in to this changing landscape.

Creative and credible: The challenge of coproduction in evidencing and developing music and arts for health and wellbeing (Norma Daykin)

Norma Daykin (Professor of Arts as Wellbeing, University of Winchester) led the second plenary address by examining the broader landscape of music and arts for health and wellbeing. Professor Daykin presented the challenges faced in evidencing the contribution of the arts, including the difficulties faced explaining the 'effects' of the arts, when, where and why to carry out evaluation, and explored the case for standard evaluation frameworks. Despite the demand for evidence of measurable outcomes by commissioners and stakeholders, there are limited standardised methodologies for evaluation of the impact of arts

on health and wellbeing. This strategic talk encouraged the audience to consider what is involved with evidencing and evaluating the use of arts in health and why we should invest in doing this. Central to her presentation was the need for coproduction in evaluating process and effectiveness, to include stakeholders (funders, service users and carers) in developing sustainable and evidenced interventions. Daykin highlighted the need for arts therapists and arts practitioners to engage in coproduction to develop a common language when appealing to and working with commissioners and stakeholders.

Again the focus on collaboration in a somewhat competitive environment seemed to function as a positive message for development of high quality yet cost effective arts-based health and social care.

Music therapists – a small band with safety in numbers and stories – leading, marching and playing with the beat (Stephen Sandford)

Stephen Sandford (Head of Arts Therapies, East London NHS Foundation Trust) delivered the final plenary address. Using the backdrop of his own professional journey, Sandford mapped the evolving state of the music therapy profession using numbers, stories and songs. Despite the undeniable financial pressure, Sandford reinforced to the audience that as a profession, music therapy continues to grow faster than any other Allied Health Profession. There is a passion and drive to move the discipline forward and to develop our work through sharing. Within Sandford's playful and humorous delivery were strategic models of partnership working. In proposing a design for a tiered approach to music therapy intervention and service, Sanford presented the work of the East London NHS Foundation Trust's Arts Therapies team which has focused on training auxiliary therapy support to use the arts in compassionate care as a bridge from treatment to maintaining wellbeing.

There was a sense of excitement in the room as Sandford's passion, creative thought and innovative ideas were shared with the audience. In our eagerness to appeal to the wider world in healthcare and share a platform with bigger professions, Sanford highlighted our tendency to often omit the music. His energetic delivery served to both congratulate and inspire the room, while reminding us of our core values as music therapists and health professionals.

ORAL PRESENTATIONS AND ROUNDTABLES

The weekend's oral presentations offered ways in which practitioners could re-vision their voices and resource music therapy for needs across the lifespan. Subject matter ranged from partnership working; short-term intervention; developing practice guidelines; formulating research and evaluation methods to pioneering music therapy in unfamiliar settings. Like many music therapists I am continuously exploring new means of measuring what I do. It was inspiring therefore to hear about the wealth of research that is taking place in music therapy, and the ways in which practitioners are designing assessment tools and outcome measures for use in partnership working and to develop practice.

Photo 3: The civic welcome reception was a wonderful opportunity for catching up. Pictured: Philippa Derrington and Clare Reynolds

Rebecca O'Connor and Dee Gray's (2016) presentation of the use of music therapy research to develop services in the neuro-rehabilitation hospital in Dublin, Ireland (where music therapy does not have statutory recognition) was an inspiring means of demonstrating the many capabilities of music therapists and the possibilities for development when we share what we do and work collaboratively. Both therapists work as part of a multi-disciplinary team in developing assessment protocols for awareness and responsiveness in patients with Prolonged Disorder of Consciousness

(PDOC) with their families. In addition to the benefits of developing research alongside practice, the unique contribution of music therapy to the assessment of awareness and responsiveness in patients with PDOC was also highlighted through video clips of the therapists' work, which taking place in a highly medical environment were often moving and emotive.

The overarching theme of re-visioning, re-defining and resourcing music therapy did not lose its urgency over the course of the weekend. With a staggering fifty talks, papers and presentations to choose from in the programme, I was left overwhelmed by both the potential and the pressure in music therapy as a profession. I was grateful of the space to take stock in Saturday's round table: *'Being pioneers in the 21st century: The state of the art of music therapy in six counties of the UK'* (Sutton, Nugent, Ward, Roche, Li, Harbinson and Wooderson), where therapists' identities, journeys, and achievements were considered against the backdrop of political uncertainty in Northern Ireland.

Here, the growth of music therapy in Northern Ireland from one to over thirty music therapists in the last thirty years was discussed with respect to the creative approaches taken to develop, maintain and sustain their work. All six therapists representing a range of cultural and training backgrounds presented their experience as 'outsiders', leading music therapy in a country familiar with cultural tensions, and considered what support and skills are necessary to navigate work as music therapy pioneers. I was struck by how powerful the exploration of themes of professional identity, isolated practice and cultural differences was when considered from six contrasting voices. Cultural issues in the therapy room between therapist and client were considered with respect to nationality, first language and religious background.

As music therapists we are all, to a large extent, outsiders, and professional differences in our places of work can often introduce similarly challenging tensions and impact on our sense of professional identity and belonging. The therapists' innovative approach to developing their practice was not only evident in how they have set up work and reduced resistance to working with the tensions of insiders/outsiders but also in their approach to writing this discussion. Through group musical improvisation themes such as identity, cultural awareness, diversity, isolation and support emerged. Excerpts from the first and last musical improvisation were played at the beginning and end of this roundtable respectively, allowing time to reflect on what unites us in an often isolating profession. The development of one voice was evident in the music and the group expressed hope to continue to meet to play, reflect and support one another in the future.

The remaining round tables explored the ever-present issue of defining and explaining music therapy among non-music therapists; developing collaborative relationships to improve access to music therapy where direct therapeutic work is not possible due to lack of resources; developing music therapy in the field of perinatal clinical services; examining approaches in delivering intensive music therapy for young children with autistic spectrum disorder; developing music therapy services for children in NHS hospital settings; and exploring the needs of freelance music therapists to promote professional approaches to fostering sustainable freelance working.

Photo 4: The Barony, a spectacular venue for the conference meal

Photo 5: 300 music therapists and a ceilidh! An evening of dancing followed the conference meal, led by the Drams Ceilidh Band

Photo 6: BAMT area group (Scotland) pop-up meeting over lunch

WORKSHOPS AND POSTERS

The variety of the workshops demonstrated the skills of so many music therapists. Practical means of re-visioning and resourcing music therapy were offered through focusing on inherent resources such as the voice and musical cultures in practice; partnerships with technology; skills sharing; and learning to market, brand and disseminate music therapy research and practice to the public.

A wealth of work was displayed in the form of posters over the course of the weekend. Innovative work with clients across the lifespan was on display and many presenters were available to engage with attendees as they viewed the material. Richard Murison (NHS Oxleas Foundation Trust) was the Delegate Poster Prize winner for his presentation *'All change: A therapeutic model of transition support'*. Claire Gillespie's poster entitled *'Creative connections: Intensive interaction training in a residential service for people with profound and multiple learning disabilities'* won the scientific committee vote. Both the visual representation of the work and the work itself was received as highly relevant in re-visioning and resourcing music therapy for contemporary needs and a clear role for the music therapist in consultancy and education was again identified.

SUMMARY

Although the wealth of presentations, the number of experienced researchers and practitioners in the field and good company could well have justified another day in Glasgow, the conference came to a close on Sunday afternoon. Those seeking inspiration, contact and dialogue will not have been disappointed. It is a busy time for music therapy and indeed the arts therapies in the UK, and it is encouraging to witness the growth of music therapy and the innovative ways colleagues and partners are creating opportunities from the hub of London to the extremities of the Shetland Islands. Music therapists are outward facing in their approach to health and social care in the UK and in taking their place on the changing landscape. The opportunity to spend time within our professional group is invaluable. In isolated practice it is perhaps too easy to remain an 'outsider', which can have a negative impact on the growth of the profession, and indeed services. By first sharing the work music therapists can become stronger and more confident in wearing our 'many hats' to grow, develop and make music with others.

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Conference report

The Third Nordoff Robbins *Plus* Conference

'Exploring music in therapeutic and community settings'

Katie Rose Sanfilippo & Neta Spiro

The Third Nordoff Robbins *Plus* Conference
'Exploring music in therapeutic and community settings'

17 May 2016

Nordoff Robbins & Goldsmiths, University of London, UK

Katie Rose Sanfilippo is a psychology PhD student at Goldsmiths, University of London under the supervision of Prof Lauren Stewart. Her current research investigates the potential of a musical intervention in helping anxious and depressed pregnant women and their infants. She is also a research assistant at Nordoff Robbins. She recently completed her MSc in Music, Mind and Brain at Goldsmiths. She is originally from California where she received at BA in vocal performance and choral conducting along with another BA in psychology.

Email: katierose.sanfilippo@nordoff-robbins.org.uk

Neta Spiro, PhD, is Head of Research at Nordoff Robbins, London, UK and a member of the Faculty of Music, University of Cambridge, UK.

Email: neta.spiro@nordoff-robbins.org.uk

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"Music has been imbued with curative, therapeutic, and other medical value throughout history". It is seen as "ubiquitous... emotional... engaging... distracting... physical... ambiguous... social... communicative... [affecting] behaviour and identities" (Macdonald, Kreutz & Mitchell 2012: 4-6). It is unsurprising, therefore, that people with many professional and personal backgrounds find themselves engaged in, and communicating about, music. From music therapy to neuroscience, questions about music are being asked about its role, how we engage with it and the "effects" of doing so. Each field brings with it a set of assumptions and methods. These assumptions and methods help to inform research and practice. If a common goal of these disciplines and individuals is broadly the same – to understand music, its role, how we make music and why this might be important – then bridges of communication and collaboration might be fruitful. The bridges are

made strong by the combination of understanding what each individual researcher, artist, client, practitioner or professional has to offer. These bridges will help to reach a more comprehensive picture of music, its role, and its importance.

Since the inaugural conference, which took place in September 2013, the Nordoff Robbins *Plus* Research Conference series has worked to create a dialogue between music therapy and other disciplines and professions (Spiro & Schober 2014). This interdisciplinary dialogue is important to the work at Nordoff Robbins – an organisation that combines music therapy provision, education and research. This conference report provides an opportunity to share what we learnt at the 2016 Nordoff Robbins *Plus* Research Conference, through summaries and discussion of the sessions. We also invite expressions of interest for future collaboration and participants' own responses to the day.

On Tuesday 17th May 2016 people with an eclectic range of backgrounds, including music therapists, music psychologists, arts and health specialists and musicians gathered to build bridges during the conference at the Nordoff Robbins Centre in London, UK. The conference was co-organised with Goldsmiths University of London, a university which also validates Nordoff Robbins' masters and doctoral training courses. The conference entitled *Exploring music in therapeutic and community settings* (Spiro et al. 2016) featured six speakers who all undertook explorations through presentations of their own work or research. The aim of the day was to discuss how music is used in diverse contexts and how it is studied within different disciplines. This dialogue works to provide opportunities for multi-disciplinary and cross-institutional collaboration and discussion. The speakers therefore came from different backgrounds as researchers, music therapists and a mix of the two. Their talks covered different topics such as music therapy in different contexts with different populations, a discussion of challenges and relationships between practice and research, academic investigations of communication in music-making and research on musical interventions from the viewpoint of neuroscience and music psychology. The poster session also included presenters from different backgrounds covering evaluation, education and professionalism, stroke and dementia, and musical improvisation.

MUSIC THERAPY IN DIFFERENT COMMUNITIES AND CONTEXTS

Music therapists work in different communities and contexts and these have different challenges and working relationships. Three of the speakers at the conference are practicing Nordoff Robbins music therapists working in different settings and with different vulnerable populations. They each spoke about their adaptability as practitioners and the larger network involved in music therapy in community settings.

Nicky O'Neill opened the conference by presenting her work with children with complex needs within an acute ward at Great Ormond Street Hospital. She discussed how she navigates the various relationships involved in working within this paediatric hospital setting (for related work see: O'Neill & Pavlicevic 2003). Each child may have any range and combination of referral areas (moods, moves and music) and their care involves various teams of people within the hospital setting. This type of setting presents its own challenges and O'Neill used a car analogy to describe how one might navigate within this context as a music therapist. She described how one needs to be both a race car, as the environment is fast-paced and has urgency, but also needs to be able to go "off road" and be creative when presented with a new challenge.

Esma Perkins, through a presentation of her work with students with Autism Spectrum Disorder, also explained the complexity and intricacies of practicing music therapy within a wider context. She described through video examples and case studies how the individual closed music therapy sessions with students at Wargrave House School introduced a culture of, and comfort with, everyday music-making. This, in turn, she suggested has "therapeutic benefit for the whole school community".

Jimmy Lyons, through presenting his work at the Teenage Cancer Trust at University College London, investigated how in the context of a hospital, working with vulnerable populations and with different teams and collaborators presents its own challenges. Teenagers are in a multi-faceted developmental period in their lives. Lyons explained how his multi-disciplinary approach to music therapy, involving music lessons, individual and group therapy sessions both within the in-patient and outpatient wards happen flexibly within the hospital setting as a way to meet the complex and

wide ranging needs of both the teenage patients and their families.

These three speakers illuminated the multi-faceted nature of music therapy within a wider context. Music therapy, we learned, involves creative solutions to complex problems, meeting the needs of not only the patients but the wider community. They also work with a wide range of professionals and teams. Clearly, these approaches to music therapy do not occur in isolation (for example: Pavlicevic et al. 2015; Wood 2016, among many). Each speaker presented examples of case studies and corresponding video clips. Their presentations inspire a range of research questions, which might be narrowly or more broadly focussed. These research questions might use different types of designs and methodologies and might investigate further how music therapy happens in these contexts and the effects music therapy might have in different contexts with different communities. As the context and client groups vary, choices arise regarding appropriate methods and designs that might inform practice alongside fundamental questions. Such questions might include: What is happening in music therapy sessions and why? What effects of this work can be seen by whom and for whom? How might music therapy research inform music therapy practice as well as other disciplines such as music and health, or music education? These questions present opportunities for research within music therapy and within other disciplines. Just as the working environments and needs of clients of music therapists raise questions, so does the relationship between practice and research. This complexity was addressed in Claire Flower's presentation.

COMPLEXITY BETWEEN RESEARCH AND PRACTICE

Claire Flower is a music therapist working within the Cheyne Child Development Service at Chelsea and Westminster Hospital and is also working towards a PhD at Nordoff Robbins. From this position she confronts the tensions between research and practice. She described the feeling as being splayed across a fence, not on either side, but uncomfortably right on top of it. As part of her PhD research, which was inspired and continues to be influenced by her practice, she investigated a trio – client, parent and music therapist – and the relationship between the participants (Flower 2014). Using video analysis, she explored the intricacies of this relationship. Writing a 'score' of the sessions, she was working to understand how each participant responds to one another, to the context of the session as well as to the music. She went on to explain how practice-led research can elicit questions of both the practitioner and the researcher, and how some of these questions can present tensions between the two roles.

This complexity and tension can not only be seen in an individual's struggle to meet the demands of both roles, but can also be seen in the practicalities of research design, methodology and ethics: represented in Flower's image of being between two fences – constantly teetering from one side to the other. Some research and some forms of practice do have differences: differences in assumptions, objectives and methods. However, instead of seeing these differences as fences, we suggest the image of a bridge. From this perspective, we do not have to be on one side or the other, separated by a wall or barrier. Instead, we can be directly in the middle, comfortably looking over the river as it passes by. A bridge gives the image of meeting half way, finding a way to overcome challenges through the building of a new pathway.

With three more speakers, we saw the variety of research approaches that can be relevant to music in therapeutic and community settings. The speakers work within different academic research communities and presented different topics with their own research designs and methods. Even though research and practice can sometimes be seen on either side of fences, a bridge can be built in the similarity of desire to understand music making and its therapeutic effects and its communicative abilities.

ACADEMIC RESEARCH INVESTIGATING MUSIC-MAKING WITHIN THE THERAPEUTIC AND COMMUNITY SETTING

The inclusion in the conference of these speakers presented the audience with different perspectives and an opportunity to engage and think about connections with previous talks and possible inter-disciplinary relevance.

Nikki Moran, a senior lecturer and program director of music at Reid School of Music, University of Edinburgh, discussed research that investigates music performance in different contexts, within and beyond the realm of western classical music (Moran 2013). She challenged the

notion and bias of music researchers and practitioners towards the prominence of Western classical music and musical notation. All of the studies she presented investigate some aspect of musical communication; from the nonverbal communication between players in North Indian classical duos to the communication of a conductor leading a small classical ensemble. She presented different methods and technologies, such as motion capture and video analysis that were drawn from different disciplinary frameworks ranging from ethnomusicology and sports science.

The keynote speaker, Lauren Stewart was a primary collaborator in organising this conference. Professor in Psychology at Goldsmiths, University of London and leader of a research group and MSc program in Music, Minds and Brain, she also gave examples of current research she and her team are working on. She first presented assumptions within neuroscience about music processing and engagement. Lauren Stewart explained how music is an active process as the brain works to make sense of the sound signals of the outside world. She explained how we learn to make sense of the musical world, revealing the expertise of the listener. She gave evidence of all brain areas being used in music processing as well as the idea that perception and emotion can dissociate. These descriptions gave a backdrop for the ideas, assumptions and understandings within music psychology and neuroscience research. The example studies that Lauren Stewart presented investigated how music making might play a role in the cognitive and motor rehabilitation of stroke survivors and patients suffering from chronic neglect (Bodak et al. 2014). She also presented different research methods and assumptions used within different disciplinary fields such as neuroscience, psychology and computer science. Pedro Kirk, a PhD student with Lauren Stewart, presented his work which uses digital music as a means of music making within a therapeutic setting, helping in the home rehabilitation of hemiparetic stroke survivors.

These speakers, academic researchers by trade, presented assumptions held and a wide variety of methods used within their fields and other related disciplines. They discussed how technologies have added to the types of research that can be undertaken and broaden the type of musical activity can be included in therapeutic music-making. The variety in the methods and research they presented gave insight into how music is being studied not just as a function or tool to be used but also as an experience in and of itself. Both types of research draw from different methodologies, use new technologies and add to the conversation of music within therapeutic and community settings. All these presentations together left the audience with the task of finding similarities, thinking about challenges and seeking collaboration.

DISCUSSION: BUILDING BRIDGES OF COMMUNICATION AND COLLABORATION

The conference ended with small and large group discussions exploring: (1) what research questions people would like to ask about the music therapy work presented and (2) how future initiatives in music in therapeutic and community settings could be informed by the music therapy work and the research questions and methods presented. The fruitful discussions led to questions of practicality when investigating research, presentation of evidence, and feelings of a need to collaborate. This activity was crucial to the conference as it allowed for active participation in the conversation and began to build the foundation towards a bridge of communication and collaboration.[1]

Throughout the conference different perspectives, practices, contexts and methodologies were presented, each working towards understanding music and what role it plays in particular communities and contexts. Each speaker gave comprehensive insight into their own experience, challenges and understanding within their own communities and disciplines. To find a holistic understanding of what role music plays within society more generally, how and why music-making and music therapy should be used within different communities and contexts, and what methods or technologies might best tackle certain research questions, true interdisciplinary collaboration must take place. Each discipline has its own strengths, challenges and limitations, and collaboration is not always easy (Tsiris et al. 2016). By working together we might be able to investigate and explore more fully music in therapeutic and community settings and contribute to the wider knowledge of music within society. This conference was a step along the path to more active collaboration and zealous discussion. This needs to take place so that the advantages of different perspectives can be combined. Working toward

[1] The conference also included the announcement of two new publications: Wood (2016) and Cripps et al. (2016).

building bridges benefits the whole, allowing for a coming together leading to stronger understanding, practice and research.

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Conference report

Research and Practice: Right and Wrong – A Joint Conference for Counselling, Psychotherapy and the Arts Therapies

Beth Pickard

Research and Practice: Right and Wrong – A Joint Conference for Counselling, Psychotherapy and the Arts Therapies

27 June 2015

University of South Wales Centre for Counselling and Psychotherapy Research, UK

Beth Pickard is a Senior Music Lecturer at the University of South Wales, and is graduating this summer from the MA Music Therapy at the University of the West of England, where she received the McMullen Disability Prize for her work on self-identity, neuro-rehabilitation and music therapy. Beth completed her undergraduate studies at the Royal Welsh College of Music and Drama where she received the Principal's Award for her research into Music and Down's Syndrome. Whilst working in education with a focus on additional learning needs and disability, Beth completed an MSc in Applied Psychology of Intellectual Disabilities with the University of Portsmouth. Beth is a trustee of the Birmingham-based charity 'Melody' which promotes instrumental tuition and musical opportunities for children and young people who have learning disabilities.

Email: beth.pickard@southwales.ac.uk

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INTRODUCTION

This report provides a summary of the 8th annual conference of the University of South Wales (USW) Centre for Counselling and Psychotherapy Research, held at USW Caerleon Campus on Saturday 27th June 2015. Primarily aimed at counsellors, psychotherapists and arts therapists interested in exploring and developing their practice potential, delegates were presented with the latest in research papers as well as a choice of workshops. The conference was well-attended with 65 delegates comprising students, graduates, and a lively mix of academics and practitioners; with representatives from CAMHS, CMHT and Learning Disabilities NHS teams in England and Wales, in addition to representatives from further education, the major Third Sector providers and large and small private practices. Delegates came from across South Wales, the borders and South West, and even from the University of Jyväskylä, Finland.

CONFERENCE PROGRAMME

Dr Peter Mayer, Head of the School of Psychology, Early Years and Therapeutic Studies at the University of South Wales, declared the conference open; presenting the notion of how important the sharing and embedding of research and practice is between academics and students, as well as the bright future of counselling and psychotherapy at USW with the imminent move to a purpose-built

Therapeutic Studies department at USW Newport City Campus. The regional impact of the Newport Community Counselling Service was also referenced as an important context for this annual event.

There were two keynote presentations during the day, the first by Professor Colin Feltham PhD, FBACP, who is Emeritus Professor of Critical Counselling Studies at Sheffield Hallam University and External Associate Professor of Humanistic Psychology at the University of Southern Denmark. Professor Feltham's thought-provoking presentation, entitled *'Is Our Research on the Wrong Path? Some Critical Thoughts'* invited delegates to recognise the usefully constructive nature of criticality and to challenge certain assumptions and dominant research paradigms. A detailed and theoretically underpinned overview of psychotherapy research was provided, encouraging delegates to consider the common factors between modalities. Current challenges in researching practice in the fields of counselling, psychotherapy and the arts therapies were discussed, as well as some of the constraints of researching within a Higher Education context. The notions of uncomfortable or inconvenient findings and difficult research questions were considered; these were explored in more detail in a subsequent workshop later in the day.

Feltham concluded by summarising that the concept of critical thinking is under-developed and neglected both in training and in practice, questioning whether the divorce between practitioners and theorists can continue. Imaginative approaches to conducting research were encouraged, as well as recognising "what we can do well".

Photo 1: Professor Colin Feltham's keynote presentation

Following this inspiring keynote presentation, delegates could transition to one of two academic paper presentations. The first, *'Are we Rationalists or Tragedians: Redefining Therapy as an Aesthetic Act'* presented by Nicola Blunden of USW and Markku Nivalainen of the University of Jyväskylä, Finland; considered the apparent contradictions presented by the rational discourse of the mind and the poetic cries of the heart and the impact of this dichotomy on evidencing practice. This entertaining and thought-provoking presentation used Greek tragedy to explore the pain that reason may have suppressed, proposing tentative suggestions for how we might return the poets to the therapeutic polis, and use an aesthetic model to evidence practice.

The second academic paper entitled *'Insider/Outsider: Considerations Regarding Data Reliability in the Evaluation of Project Beit Sahour, A West Bank Therapeutic Music Project'* was presented by music therapist and USW MA Music Therapy course leader, Liz Coombes, on her work with USW occupational psychologist Michal Tombs (Coombes & Tombs-Katz 2015). This collaborative paper provided an evaluation of the therapeutic music project that took place in the West Bank in two mainstream schools, with particular emphasis on trainee motivation, training programme quality and subsequent use and embedding of knowledge and skills; exploring theories such as Motivation to Learn (Noe & Schmitt 1986; Colquitt, LePine & Noe 2000), Instrumentality (Tharenou 2001) and Social Exchange Theory (McDonell et al. 2006).

Photo 2: Liz Coombes presents Project Beit Sahour

The "insider/outsider" position of the trainer as researcher was also considered: its impact upon the validity of the results and also its contribution to the authenticity of responses. Linguistic differences were also noted to have a possible impact upon responses and results, and the potential of interviews to address some of these issues in future research. This innovative approach to

sharing therapeutic music practice with communities in areas of conflict was also an opportunity to reflect upon researching practice and ensuring the rigour and validity of the design of such research.

Following these academic paper presentations were two workshops for delegates to choose to attend. The first, *'Drifting in Each Other's Thoughts: A Cross-Modality Workshop Exploring How Different Approaches Synthesize in Practice with a Particular Focus on Therapist Drift, the Use of Story, Counsellor Agency, and Patient Diagnosis'* by Jack Rochon, Elaine Davies, Julie Dorey and Catherine Jones was a collaborative, multi-disciplinary exploration of diverse practice approaches in search of synthesis.

The workshop represented the collective biographies of the Cardiff Psychotherapeutic Research and Practice Study Group synthesised into four emblematic but simple therapeutic elements, considering potentially transferable and effective ways of working between what are often considered to be incompatible ways of working. Embedded within a framework of social constructionist, constructivist, post-structuralist and structuralist cultures, the activities were designed to encourage a critical stance toward taken-for-granted ways of understanding one another's practice. Delegates were invited to consider their therapeutic sessions as art installations, cultural artefacts: multisensory and multidimensional. This highly innovative and collaborative session provided much challenging food for thought for delegates of all disciplines and modalities.

Photo 3: Cath Jones, Elaine Davies and Jack Rochon present their cross-modality workshop

The second workshop, presented by Penny Hallas and Lydia Cleaves, was entitled *'Virtual Meeting Place: New Technologies and Approaches in Art Therapy and Dramatherapy'*. This workshop explored the way gesture-based technology provides a framework to hold and contain emotion as well as facilitating expression and insight into self and relationships.

Following a networking lunch break where delegates were able to browse and purchase texts from local publishers PCCS Books, the second keynote presentation opened the afternoon's proceedings. USW welcomed eminent art psychotherapist and group analyst, Professor Diane Waller, who is Emeritus Professor of Art Psychotherapy at Goldsmiths, University of London; Honorary Professor in the Centre for Mental Health, Imperial College; chair of the International Centre for Research in the Arts Therapies; and Principal Research Fellow, School of Applied Social Science, Brighton. Waller's presentation focused on the theme: *'Practitioners Becoming Researchers: Some Dilemmas'*, describing research as a "creative process". External influences on research were considered as well as the place of the arts therapies within such structures, and the inherent values of research.

Photo 4: Prof Diane Waller's keynote presentation

Waller insightfully shared the learning from her own research projects, reflecting on often unexpected outcomes which posed further questions or challenges; concluding by noting that as long as research is ethically sound, "there is no '*wrong*' research". She noted that we should not be afraid of embarking upon research as practitioners, valuing our own skills and collaborating with specialists to ensure the rigour of research methods.

The next session provided an opportunity for delegates to attend one of three sessions where academic papers were presented. The first was led by Cate Harding-Jones, presenting and discussing

the research question: *'Sex Trafficking and Counselling: Are the Needs of Trafficked People in Wales Being Met?'* Concurrently, Kirsty Bilski presented *'Chasing and Befriending Transference in Sand Tray Supervision'*, considering how existing supervision models and theory integrate to underpin the use of Sand Tray in counselling supervision, and what the potential benefits of its use may be. The third academic paper presentation during this session was *'When Love is Not Enough: Music Therapy with Adoptions in Crisis, An Evaluation of Findings Arising From Clinical Cases and Discussed in Light of Contemporary Attachment Thinking From the Fields of Neurobiology and Relational Psychotherapy'*, presented by music therapist, Joy Gravestock. A creative and thoughtful context was provided for the presentation framed by the story of The Velveteen Rabbit (Williams 1922):

> "It doesn't happen all at once", said the skin horse, "You become. It takes a long time" (Williams 1922, cited in Gravestock 2015).

Gravestock considered research to be the practice of "sharing stories about our work", first and foremost as a clinician focused on the clinical work; not an expert, but a practitioner on a continuing journey. A quotation from music therapist Jacqueline Robarts supported this practice-based approach to research: "Clinical work is the most trustworthy route to theoretical understanding" (Robarts 2014). Clinical work was presented and its theoretical orientation discussed, with reference to intersubjective theory (Stern 2010); developmental neuroscience and neuropsychology (Gallese & Ammaniti 2014), relational psychotherapy (Schore 1994), modern attachment theory and trauma related theory (Wilkinson 2006, 2010).

Photo 5: Joy Gravestock presenting about music therapy in adoption

Extracts of clinical work with adoptive families illustrated the theoretical constructs presented and brought to life the presentation with examples of communicative musicality (Malloch & Trevarthen 2010) and affect attunement (Stern 2010) shared and reflected upon. Ethical considerations were presented in specific relation to completing clinical work and research with this individualised client group.

The final session was a mixture of academic paper presentations and workshop options for delegates to attend. Rachel Waters presented *'Carers' Beliefs About Counselling: Expectations and Understanding'* which aimed to explore whether and how carers thought that counselling might help with difficulties associated with the caring role through a community-based participatory approach to research. Hayley Bartlett presented *'The Relationship Between Predictor Variables and Counselling Outcomes in a University-Based Community Counselling Service'*, again focusing and exploring the provision of the Newport Community Counselling Service to determine 'how' and 'for whom' therapy works. This study demonstrated the effectiveness of community-based counselling with trainee therapists and adds to the literature by elucidating issues surrounding the effects of four predictor variables on counselling outcomes.

As part of the *'Art Psychotherapy and Counselling Masters Forum',* four academic papers were presented and considered for the PCCS Books sponsored Masters Prizes:

Student	Title of academic presentation
Jodie Cooper	How do art psychotherapy therapeutic art processes therapeutically enable people with dementia to process the loss of their identity to promote identity?
Rhiannon Gray	Several shades of grey: A creative exploration of life as a trainee art psychotherapist in response to everyday life and conflicting roles
Imogen Harries	How the working environment of a secondary school impacts on what counsellors require from their supervision
Amy Wilson	Art therapy and the picture previously unseen: An exploration of interpersonal relationships through artwork

Table 1: Art psychotherapy and counselling Masters student presentations

The final workshop session was facilitated by Professor Colin Feltham, entitled *'Radical Honesty and Critico-Creative Thinking as Research Stimuli'*, based on the challenge that "much research in our field is pedestrian, convenience-driven and open to improvement". Using Brad Blanton's practice of 'radical honesty' (Blanton 2005) combined with free associative brainstorming, delegates were encouraged to identify topics and methods for research that have been accidentally neglected or passed over out of difficulty or sensitivity. Suspension of conventional thinking and "openness to radical new ideas in research" was encouraged.

SUMMARY

The plenary session was an opportunity to celebrate the diversity and creativity of the sessions presented and facilitated throughout the day, with comments and questions from delegates to presenters and organisers. Dr Sheila Spong, Head of Counselling and Psychotherapy at the University of South Wales, expressed her gratitude to Jack Rochon, Blanka Hubena and Helen Jury from USW for arranging and hosting the event so efficiently; and also thanked the USW School of Psychology, Early Years and Therapeutic Studies for funding three student places at the conference. The PCCS Books Award for Masters Level Research was presented to Imogen Harris, and the PCCS Books Art Psychotherapy Prize was awarded to Jodie Lee Cooper.

Photo 6: Imogen Williams is awarded the PCCS Books prize for MA dissertation in counselling and psychotherapy subject area

Photo 7: Jodie Lee Cooper is awarded the MA Art Psychotherapy prize from PCCS Books

It was summarised that the sharing of practice and approaches between modalities had been informative and inspiring, and that the notion of collaborative research was positive, possible and exciting.

The USW Therapeutic Studies team are excited to welcome colleagues from Play Therapy and Systemic Family Therapy to join the research conference next year, which will be held on Saturday 2nd July 2016 at the University of South Wales.

Photo 8: Dr Sheila Spong thanks the USW team who coordinated the conference

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Conference report

25th Annual Conference of the International Association for Forensic Psychotherapy (IAFP)

Forensic Music Therapy Symposium
'European music therapy research perspectives on recovery in forensic families'

Stella Compton Dickinson

25th Annual Conference of the International Association for Forensic Psychotherapy (IAFP)

Forensic Music Therapy Symposium:
'European music therapy research perspectives on recovery in forensic families'

7-10 April 2016

Ghent, Belgium

Dr Stella Compton Dickinson was Head of Arts Therapies at the Rampton High Secure Hospital (2001-2009), Clinical Research Lead (2009-2013), fellow and member of The Institute of Mental Health, Nottingham.

Email: stella.comptondickinson@gmail.com

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Inspired by their Honorary Life President Dr Estela Welldon, the International Association for Forensic Psychotherapy (IAFP) has supported the development of music therapy and art therapy in forensic psychiatric hospitals and prison settings for many years. United Kingdom (UK) music therapists, Alex Maguire (Broadmoor Hospital) and Stella Compton Dickinson (Rampton Hospital) have both independently presented on several occasions at IAFP conferences.

The overall title of the conference was: *'Families: How to survive them – or not... An analysis of the dangerous family and societal response'*. Presentations began with a plenary on working with mothers and babies when unresolved maternal trauma threatens a baby's safe development (Amanda Jones, UK) followed by a choice of parallel sessions from forensic psychotherapeutic work which included *'Catathymic rage, dissociation and domestic violence: Psychotherapeutic and neuroscientific aspects of domestic violence'* (Leslie Lothstein, USA). Cognitive analytic therapy for patients within forensic settings led by Phyllis Annesley, including three presentations*: 'Traumatic attachments and re-enactments'* (Phyllis Annesley, UK); *'Cognitive*

analytic therapy contribution to understanding anti-social personality disorder in a forensic setting' (Andrea Daykin, UK); *'Re-forming the family: Group cognitive analytic music therapy (G-CAMT) with patients suffering with schizophrenia'* (Stella Compton Dickinson, UK). Other parallel sessions covered five settings; homicide, female offenders in treatment; therapeutic approaches in detention; families, sex offenders and offence mirroring.

The present report features parallel session 5 *'European music therapy research perspectives on recovery in forensic families'*. This was held in the main conference hall. After which there was lively discussion by delegates in a large group analytic session regarding the value of the context specific models of forensic music therapy presented.

Four European perspectives of mixed methods forensic music therapy research were presented. This included two clinically tested, manualised models of forensic music therapy. Stella Compton Dickinson (UK) and Laurien Hakvoort, Clare Macfarlane and Gerben Roefs (Netherlands) all demonstrated how they have approached specific aspects of forensic psychiatric treatment.

The term 'forensic music therapy' refers to the model and context of treatment for psychiatric patients who have been sentenced for committing offences. Maguire and Merrick (2013) and Lawday and Compton Dickinson (2013) describe two interdisciplinary music therapy approaches from high secure hospital treatment in the UK. The aim of forensic music therapy treatment (as opposed to punishment) is to contribute towards the overall multi-disciplinary approach in the reduction of recidivism.

Recidivism is defined in Webster's dictionary (2010) as "a tendency to slip back into a previous condition or mode of behaviour, particularly criminal behaviour". The multi-disciplinary treatment approach includes offence-related psychology treatments, occupational therapy and educational needs as well as arts and speech and language therapies. The index offence is that which resulted in the patient being sentenced through the criminal justice system to a secure treatment setting or penitentiary.

By creating robust models of music therapy that meet specific multi-disciplinary treatment needs, music therapy is becoming acceptable not only for selected patients or those who may be considered difficult to treat but for any patient who is incarcerated.

The purposes of the symposium were as follows:

1. To draw together music therapy themes in common.
2. To consider the differences in each of the approaches.
3. To disseminate the unique aspects of each of the research projects.
4. To consider how to move forward towards a larger trial in forensic music therapy models of treatment.
5. To learn from and share with our expert colleagues, forensic clinicians and delegates of other disciplines.

Hakvoort and Compton Dickinson began together by describing the overall treatment models in the UK and Netherlands.

In the UK the overall treatment approach is called The Recovery Model. This represents a movement away from pathology, illness and symptoms towards strengths and wellness. Anthony (1993) describes it as growing beyond the catastrophic effects of mental illness towards social inclusion. Shepherd, Boardman and Slade (2008) state that recovery involves building new meaning and a satisfying life as defined by the patients themselves. Mcaffrey, Edwards and Fannon, (2011) focus on the meaning of the therapeutic relationship and the potential for growth and change.

The overall treatment goals are towards the reduction of risks of violent behaviour, the development of victim empathy, remorse, and through restorative justice the desire to make amends.

The overall model of treatment in the Netherlands is called the Risk-Need-Responsivity Model (Andrews & Bonta 2010)

The aims of forensic music therapy within this approach are:

1. To assess needs and risk behaviour.
2. To meet the needs of patients through their responsivity to music.
3. To enhance functional skills towards risk minimisation (anger management, social skills, relational abilities, and to reduce impulsivity).

Cognitive Analytic Music Therapy (Compton Dickinson 2006, 2013, 2015) and Cognitive Behavioural Music Therapy (CBMT) (Hakvoort & Bogaerts 2013) are models that are both based within robust evidence-based psychotherapy models. Over many years of clinically based developments, Hakvoort and Compton Dickinson – during their doctoral studies – have independently

modelled music therapy interventions which are 'context specific' because they take into account the impact of the index offence on how risks of violence can be managed.

Hakvoort began the individual presentations by describing the results of a mixed methods multi-centred trial of her manualised cognitive behavioural music therapy model called Music Therapy Anger Management (MTAM) (Hakvoort et al. 2013). She recruited individual participants from multiple sites and implemented a pre-post test design. Nine individuals in the treatment arm received one hour a week of the treatment intervention (MTAM) compared with five individuals in the control arm who received a group-work aggression management training. Participants who received the treatment intervention showed statistically significant improvements across time in their positive coping skills and in the self-management of their psychiatric symptoms. Hakvoort conducted a detailed qualitative analysis of aspects in music therapy that can contribute to risk assessment.

Macfarlane, doctoral candidate at Vrije Universiteit Amsterdam and music therapist at PPC Vught, then described a short-term music therapy programme (n=16) for prisoners with post-traumatic stress syndrome (PTSD). She explained how neural networks in the brain can be changed, quoting MacKinnon (2012) who states that patterned, repetitive inputs can reach poorly organised neural networks that are involved in the stress response; the neural network is activated and changed through this process of repetition. Macfarlane's doctoral studies are in progress and this pilot was designed to provide an alternative effective treatment for those who were unable to participate in treatment by Eye Movement Desensitization Reprogramming (EMDR).

Roefs (University of Applied Sciences, Utrecht, and music therapist at FPC de Kijvelanden, Poortugaal) then described Musical Attention Control Training (MACT) (Thaut & Hoemberg 2014); an evidence-based Neurologic Music Therapy intervention in rehabilitation for improving cognitive functioning – i.e. attention control for forensic patients suffering from schizophrenia. Gerben referred to the model of treatment for schizophrenia by Millan et al. (2014) that is a compatible 'top-down' cognitive control approach. He is exploring whether music therapy research results from previous studies for patients with schizophrenia, using structured improvisation techniques and songs, can be generalised to the Dutch forensic population.

Finally, Compton Dickinson (Anglia Ruskin University, Cambridge and Institute of Psychiatry, Psychology and Neuroscience, King's College London) summarised results of a single-site feasibility mixed methods, patient preference trial into the clinical effectiveness of manualised Group Cognitive Analytic Music Therapy (G-CAMT) in secure hospital settings. Statistically significant improvements in favour of the treatment group compared to control were found in domains of relatedness to others. The external observational measure demonstrated statistically significant improvements in sociability and hostility at the eight-week follow-up. Treatment effect was greatest in treatment resistant patients above the median age. The qualitative analysis of the music therapists' observations and experiences was triangulated with the statistical results of the primary and secondary outcome measures.

All the researchers agreed that more research is needed on a much larger sample in which the different models could be tested. Compton Dickinson and Hakvoort are now collaborating in writing and publishing *The Clinicians' Guide to Forensic Music Therapy* (to be published by Jessica Kingsley Publishers). This is intended to help clinicians who are new to forensic treatment and it will ensure that the two manualised models are available for wider use.

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Tribute

A tribute to Oliver Sacks

9 July 1933 – 30 August 2015

Concetta M. Tomaino

Institute for Music and Neurologic Function in New York, USA.

Editorial note: This manuscript is an expansion of a tribute first published in *Medscape*[1]; material is used here with permission.

"Every sickness is a musical problem; Every cure a musical solution" Novalis. Welcome, Ollie.

This hand-written note, on a torn piece of loose leaf paper, was sent to me via interoffice mail, thirty-five years ago, in March of 1980. "Ollie" I learned was the attending neurologist, Oliver Sacks. It was my first week at Beth Abraham Hospital, home to his *Awakenings*[2] patients, and my new job as the music therapist. I had spent the two previous years at a skilled nursing facility in East New York where I had seen the dramatic impact music had on residents with end stage dementia. These residents, I was told, "had no brains left". However when I sang and played music for them they could recognise familiar songs and recall lyrics. No-one at the facility could understand my excitement of the prospect that music could reach those with dementia. So you could imagine my delight when I received that strange torn note. The staff neurologist seemed to understand the role of music in medicine. I was eager to find out who "Ollie" was. It would be a few weeks before I met him in person.

Photo 1: Concetta Tomaino, Oliver Sacks and Dustin Hoffman (Music Has Power™ Awards, New York, 2006)

I was assigned to the units where those awoken with L-dopa still resided. Most were in wheelchairs, totally dependent in their daily care yet still could sing with full voice and lose their hyperkinetic movement when engaged in drumming or moving to music. In their charts I would find a neurology note and request to "the music therapist" to describe "how was she in music", "can she replicate a rhythmic pattern", "does she initiate movement". I began to look at my clinical work more closely – what in the music allowed these responses to occur? One day I saw one of my patients who was nonverbal, physically rigid, and with severe dementia waiting in line for her neurology evaluation. I stood there until the neurologist appeared.

- "Dr. Sacks, this is my patient, would you like to see how she responds to music?"

- "Oh, yes, do bring her in" he replied enthusiastically.

[1] To access the manuscript on Medscape, click on the link: www.medscape.com/viewarticle/842267

[2] *Awakenings* (publication date: 1973, revised edition 1990): the classic account of survivors of the encephalitic lethargica and their return to the world after decades of 'sleep'. This book was the inspiration for the 1990 film starring Robert De Niro and Robin Williams as Dr. Sacks.

Thus began our first session together. I observed as this somewhat quiet and socially awkward physician sat face-to-face with the patient, gently holding both her hands and softly singing “Daisy, Daisy la,la,la, la la la”. She opened her eyes, moved her hands in his and smiled. I told him I used a different song – *When the Saints Go Marching In*. He asked me to sit with her and sing it. I too sat face-to-face, held her hands and started to sing “oh when the Saints” – to which she immediately chimed in “go marching in”. He was amazed and delighted.

For the months that followed I had more opportunities to meet him and share questions about music and neurology. I soon learned he lived near me in Bronx. He invited me to his new home on City Island where he shared the personally written journals of the awakenings patients. These journals were filled with personal accounts of each of my patients during the period when they were able to move around and interact freely with others. It also contained the not so nice accounts of what it was like to be spoon-fed and treated like a child. It opened my eyes to the inner worlds and minds of our patients.

He gave me a copy of his book *Awakenings* (Sacks 1976) which was out of print at the time. Throughout the book, Oliver cites examples of his patients’ new mobility as “remusiking” – that the flow of movement was restored with music. The music provided an order, a temporal patterning that allowed for action where inaction had been the norm. We began to discuss what it was about music that could reach our patients so quickly and deeply. For each question I had, Oliver pulled a book from his collection of first editions, Henry Head, Hughlings Jackson, Darwin and introduced me to the founding fathers of neurology and evolutionary science. He gave me copies of A. R. Luria’s book, *The Man with a Shattered World* (Luria 1972) as my introduction to how a damaged mind has to reconstruct the world to be engaged with it. I shared information about the field of music therapy, of the potential for treating people with music.

We were excited by the prospect that music was able to change and improve our patients’ brain function in ways not yet understood. The concept of neuroplasticity was very new.

In the mid ‘80s we met with several scientists to see if they could help us study music and the brain but they laughed and said music was too complex and the science of the brain still too new. The concept of music, especially rhythm, to restore action was highlighted in Oliver’s *A Leg to Stand On* (Sacks 1984) which chronicled his own recovery from a leg injury.

Photo 2: Lesley Stahl, Oliver Sacks, Concetta Tomaino, Petr Janata and Stanley Jordan (World Science Festival)

In the late ‘80s I became president of the American Association for Music Therapy and invited Oliver to speak at our national conference in Boston as well as the North American Music Therapy conference in Toronto. In 1991 Oliver was invited to give testimony at the Senate Hearing on the revision of the Older American’s Act. This landmark hearing further introduced Oliver to the music therapy community as well as drew public attention to the importance of access to music therapy for those aging in institutions as well as those elders living well in their communities. The hearing had followed the release of the Oscar-nominated film *Awakenings* based on Oliver’s book of the same name. Several scenes in the movie illustrated the power of music to awaken the patients into active engagement and movement.

In 1993, I organised a symposium on Clinical Applications of Music in Neurologic Rehabilitation and Oliver gave the keynote “Music and the Brain”. With the success of the symposium our hospitals’ board of directors gave us support to create the *Institute for Music and Neurologic Function* (New York, USA, http://musictherapy.imnf.org) whose mission is to scientifically explore music and the brain in order to develop more effective music therapy treatments to awaken, stimulate and heal through the extraordinary power of music. Oliver has been an advisor since its inception and I the executive director. That same year I submitted a grant request to the New York State Department of Health to research, along with Dr. Sacks, the impact of familiar music on memory function in those with dementia.

His writings have continued to highlight the important role of music in the lives of those with a variety of neurologic conditions. *The Man who Mistook his Wife for a Hat* (1985); *An Anthropologist on Mars* (1995); and his book fully devoted to music and the human experience, *Musicophilia* (2007). In addition, his numerous lectures, interviews and letters have contributed greatly to our growing understanding of the power of music to awaken and heal.

It is impossible for me to describe the impact his mentoring and friendship has had on my work and my life over all these years. I am eternally grateful for this amazingly brilliant, generous and caring man who has taught me so much about the mind but most importantly of the humanity and individual spirit of the patients we care for.

SUGGESTED LINKS & VIDEOS

- Quotes by Oliver Sacks on the power of music: http://mic.com/articles/111150/11-beautiful-oliver-sacks-quotes-that-capture-the-power-of-music#.5udHkwrDj
- Forever Young: 1991 Senate hearings for the Older American's Act – Oliver Sacks Testimony: https://www.youtube.com/watch?v=53gsB81Z6qc
- Oliver Sacks' acceptance speech at the 2006 Music Has Power™ Awards: https://www.youtube.com/watch?v=qF4PwtU7y3I
- Dustin Hoffman presents Music Has Power Award to Dr Sacks: https://www.youtube.com/watch?v=vtHyj3BXgM0
- *"Partnerships in Care: Uses of Music Therapy in Medical Settings"*; video of Sacks and Tomaino at work included in the video from AMTA: https://www.youtube.com/watch?v=jVEhwmq_jF4

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Tribute

A tribute to Andrew O'Hanrahan

23 February 1959 – 25 July 2015

Jonathan Perkins[1], Amelia Oldfield[2], Hayley Hind[3], Emily Corke[4], Ruth Oreschnick[3], Nicky Haire[5] & Philippa Derrington[6]

[1]Freelance, UK; [2]Anglia Ruskin University, UK; [3]Cambridgeshire and Peterborough NHS Foundation Trust, UK; [4]Freelance, UK; [5]NHS Lothian, UK; [6]Queen Margaret University, UK.

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Jonathan Perkins

My dear friend, Andrew O'Hanrahan, sadly died on July 25th 2015 after a determined but tragically short battle with a terribly aggressive cancer.

Andrew and I met in 2005 in a small room at Anglia Ruskin University, where we sat waiting to be interviewed for the music therapy course. We found common ground between us and discovered that we had both come along that day through hope – hope that being a music therapist was something we could believe in, be good at, and ultimately find employment in. However, with laughter, we admitted to each other that we didn't have the slightest clue what this music-therapy-thing was all about, we simply hoped for enjoyment and for new directions in life.

Andrew was a kind, loving, open, warm, empathic and deeply humoured man; harmonious traits for a therapist, whilst as a music therapist he gave his innate skill as an improviser. Indeed, he was an Improviser Extraordinaire, for his ability to improvise was not just limited to the notes on a piano or the strings of a guitar**;** it was how he met with life, it was who he was in his relationships, it was how he responded to and accepted and lived with the highs and the blows, and the tragedies and the challenges of his life; it was how he moved and existed in each and every moment and fibre of his beautiful soul.

To be a good improviser is to find harmony in disorder, it is to *accept* harmony *and* disorder. Andrew lived within this realm; for as his home was full of love, so too it was cluttered and disordered; and as he was an attentive listener and a wonderful friend, so too was his world full of music and noise; and as his later life was full of therapy appointments, piano tunings, school runs, family demands, socialising, and needing to be here, there and everywhere, so too did he leave in his wake a succession of broken down and written off cars, and this meant he could be seen cycling to and from therapy appointments with a guitar strapped to his back and African drums dangling from his handlebars.

During the therapy course, my daughter, dad and I took a two-week holiday in Wales in which Andrew and the youngest three of his five children joined us for the second week. It was a brilliant, musical and fun-filled holiday. The cottage is in the middle of nowhere in the middle of Wales, and takes an age to drive to, but is well worth each and every mile once you arrive and find Shetland ponies and sheep, valleys and hills and streams. As soon as the O'Hanrahans arrived we went for a walk to explore and discover these hills. And this being Wales, it rained and it blew, and Andrew being the relaxed dad that he was – the improviser extraordinaire of parenting – he allowed his kids to jump in streams and roll down hills, to build dams and to get thoroughly wet and muddy and feel truly alive in that beautiful moment.

And so we returned to our cottage, wet and cold

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but happy. And seeking warmth Andrew began to unpack his car. He'd brought along what appeared to be the entire contents of a kitchen cupboard – half opened pasta packets, stale digestives, squash, crisps, random tins and tea bags – along with four toothbrushes, a couple of guitars and some percussion instruments. And then it suddenly dawned on him and on his muddy, wet kids that he'd entirely forgotten to pack anyone's suitcase, or bring even a single change of clothes to that oh-so-wet-and-windy-and-mud-filled part of Britain. And it was a beautiful and funny and apt thing; it reflected Andrew's innate sense of disorder and harmony; it highlighted him as the wonderful and eccentric father that he was, living in the moment of his children's happiness, and improvising and laughing at the consequences.

In remembering my dear friend, and recounting all of the very special traits that combined within him, the one defining part of him that I would like to hold on to and learn from and share would be his compassionate sense of humour. For whilst Andrew was the kindest of people, he could make the most direct and challenging observations of others, but because it was from a place of humour, compassion and love, he could do so without attacking; he had the ability to disarm a person of their bullshit without them reacting and feeling they needed to make a stink.

Photograph 1: Andrew O'Hanrahan as Jonathan Perkins' Best Man

I know that for however long I live, I shall always feel the emptiness of his absence. I always felt that we would to grow old together visiting music therapy conferences where we would gently mock the earnestness of such places. He was the kindest man I have ever known.

Amelia Oldfield

Andrew enrolled as a mature student on the music therapy MA at Anglia Ruskin University in 2005. Since qualifying he worked as a music therapist in Cambridgeshire at the Croft Unit for Child and Family Psychiatry, at several special schools, and did some sessional work with adults with learning disabilities. In April 2015 he was diagnosed with cancer, which by then had already spread from his thyroid to his lungs. He died at the end of July.

In the relatively short amount of time that he practised as a music therapist he made a strong impact on all those around him, not only on his clients but also on his colleagues. At his funeral there must have been over 250 people present, many of whom were music therapists and colleagues he had known in the last ten years of his life. The following is an only slightly altered version of the speech I gave at his funeral.

Everyone loved Andrew. He was warm, kind, clever, and often very funny. He was a wonderful listener and always gave you the impression that what you had to say was interesting, exciting and important. He was also an excellent musician, a very good pianist and a good guitar player, so perhaps it is not surprising that he became such an outstanding music therapist.

Even though we tend to have a wide mix of students from varying backgrounds on the music therapy MA at Anglia Ruskin University, Andrew was pretty unusual. He had started out as a rock musician, had trained and worked as a piano tuner and had then become a social worker, and had several years of experience working with the elderly. In addition, he was looking after his five children, and Kitty, his youngest, was only two when he started training. In spite of this wealth of life experience that he brought to the course, Andrew was humble and modest, always seeing other peoples' strengths and making positive comments to fellow students, but rarely recognising or dwelling in any way on his own talents, or past experience.

During the training, Andrew was one of a group of four students whom I saw every week for a two-hour music therapy clinical supervision session. Students would bring DVD excerpts of clinical music therapy sessions they had had on their placements to this group. I remember Andrew showing excerpts of sessions with a young woman with severe cerebral palsy with whom he was playing the guitar and conga drums. Both Andrew and his patient were having fun and were at ease with one another, and it was immediately obvious to me that Andrew was one of those few people who completely naturally and intuitively can use improvised music-making in creative ways to

connect with people. My main task was to help Andrew to recognise his own abilities.

There were, however, some aspects of the training that were challenging for Andrew. When I was guiding him through his MA dissertation, I remember him turning up to supervision sessions with no paper or anything to write with, and appearing surprised when I suggested he might want to make some notes. After a few weeks he proudly showed me a dog-eared folder containing a few scrunched up pieces of paper – he clearly wanted me to know that he was making an effort... Luckily, the main thrust of his thesis was about his clinical family music therapy work during his placement at the Croft, and he excelled at this.

After qualifying as a music therapist, Andrew worked part-time with adults with profound learning difficulties. My music therapy colleague, Dawn Loombe, supervised this work. She writes:

> "I particularly recall one piece of work, where Andrew used just his voice and his guitar to connect with a very troubled young man. The man was non-verbal and on this day, particularly anxious, shouting loudly as he wandered around, unable to settle. I will always remember Andrew's calm, gentle approach and the way he used his guitar and simple vocalising to encourage the man to calm and eventually to come to sit with him on the sofa. They 'sang' and played guitar together for some time in a very natural way; there was humour, the sharing of the guitar, and just being together. This was the first of many similar sessions. Andrew was humble, and in his work as a music therapist he just didn't know how good he was and how much difference he made to the people with whom he worked."

Photograph 2: Family Music Therapy Roundtable at the World 2014 Music Therapy Conference in Krems, Austria. From left to right: Tali Gottfried (Israel); Kirsi Tuomi (Finland); Andrew O'Hanrahan (UK) Barbara Griessmeier (Germany) and Amelia Oldfield (UK)

Andrew started to work at the Croft Unit for Child and Family Psychiatry as a music therapist in 2008. My colleagues from the Croft have contributed to the next section. Andrew adored his work at the Croft and would willingly take on any task even if it were only remotely connected to music therapy. Many members of the team will remember how last Christmas he pushed the piano from the music therapy room to the other end of the unit during the Croft Christmas lunch, and how we all sang Christmas songs while Andrew played.

He probably worked more than twice as many hours than he was paid for, and I remember that on a number of occasions several of us on the team had to tell him he was having some time off, and more or less order him to take a break. Of course he was loved and respected by the entire team, and also sometimes rather too much by some of the mothers staying residentially on the unit. However, even though he appeared very relaxed and easy going, Andrew was actually very good at recognising if a parent or a child on the unit was in danger of becoming too attached to him, and was very sensitive and professional about setting appropriate boundaries.

Andrew's enthusiasm and excitement about working with families at the Croft was infectious. As my colleague Jo Holmes, psychiatrist, remarked:

> "There were times when I was pulling out my hair because some manager or other was being unreasonable, or I was being oppressed by a tricky parent, and Andrew would just remind me of what a privilege it is to work with such a great team, doing important work."

We all enjoyed having Andrew at the Croft. He would have the reception team in stitches telling them about his latest hilarious holiday disasters, and our house keeper, Gerrie, adored him and always made sure she cooked something special for him. My male colleagues at the Croft will particularly miss him. As one remarked: "There is always safety in numbers…". Perhaps the fact that Andrew had survived difficult times himself meant that he could embrace his own individuality and encourage colleagues and clients to do the same. He had an amazing way of cutting to the heart of things, without any fuss, as well as a knack of being able to say very difficult things in a way that people never seemed to feel threatened by. Even when the rest of the team felt at their wits' end, he never lost the strength of his compassion for the positions our families at the Croft found themselves in.

Sharing a desk with Andrew at the Croft sometimes brought surprises. On one occasion when I took over the desk after he had been working there earlier in the week, I noticed the surface was a little sticky. When I lifted the computer keyboard, brown goo oozed onto my lap; apparently two days previously he had spilt a cup of coffee all over the desk just before rushing back to Cambridge to collect Kitty from school, and the clear-up job had been a little rapid….

Andrew was always keen to learn more about music therapy and we both enjoyed attending and presenting at conferences, both in the UK and abroad. He also enjoyed finding out about new aspects of different cultures although when we were in Finland he was quite firm about the fact that he was British, and could not possibly take all his clothes off in front of other male strangers in the sauna. This resolve lasted about ten minutes when his Finnish colleagues brought the beer into the sauna. He obviously adapted quite quickly because two days later he and another colleague disappeared from a restaurant on an island we had been taken to, to go skinny-dipping in a nearby lake. They were trying to be discreet about this venture, but unfortunately Andrew cut his leg quite badly on some rocks when he came out of the lake, and staggered back into the restaurant dripping blood as well as water, and urgently needing some plasters.

Photograph 3: In between conference venues at Jyväskylä, Finland, Nordic Music Therapy Conference, 2012. Andrew O'Hanrahan and Amelia Oldfield

In the last eighteen months Andrew and I have had to face a review in the NHS where we were initially told that all the arts therapy posts in the Trust were to be cut. In our meetings with the 'cutting gang' Andrew was amazingly honest and outspoken, telling one of the most senior managers in a large public meeting that his comments were "crass". After much negotiation and hours writing documents and emails we both retained slightly reduced jobs at the Croft; I will always remain grateful for his support, humour and resilience during this dreadful process.

In spite of this horrible review Andrew seemed to gain new confidence in his skills as a music therapist over the past few years. At the Croft he developed new ways of integrating theraplay techniques into his family music therapy work, and started a music therapy group for the parents. In addition to working at the Croft, he began working in a special school, one day a week, where he very much enjoyed having a music therapy student on clinical placement with him. He felt that the process of having a student helped him to be clear about what he was doing and why.

He was asked to run several music therapy workshops in different venues, and found he enjoyed doing this, although he had initially been nervous about it. Just before he became ill the school offered him another day's work which I know he was delighted about. His career as a music therapist was blossoming.

I have had many emails and phone calls from colleagues who have been shocked and saddened by the news of Andrew's death. As one of my music therapy colleagues put it: "I have lovely, smiley memories of him….ruffled, passionate and fun…."

Music therapy colleagues have already paid tribute to Andrew in various ways. He was remembered at the round table on family work at the Nordic Conference in Oslo just a few days after he died, and we had a minute's silence in his memory at the beginning of the recent dementia conference at Anglia Ruskin University.

Returning to the Croft after the summer break has been tough, as everything there reminds me of his unfailing enthusiasm and excitement about his work. Interesting though – I've picked up some of his ideas and introduced small changes in my work. I now make a point of eating with the children and the families once a week, and have found that all my short-term cases (rather than only some) consist of families rather than individual children. I wonder what he would make of this? Actually, I know the answer: he'd want to be here – doing the family music therapy.

Hayley Hind

Andrew was one of life's treasures. I knew him as a colleague, fellow musician and friend. He had such energy and passion and was always ready with a

word of support or encouragement. Andrew saw the very best in people and situations but wasn't afraid to speak out when the situation demanded it. As a clinician, his work was thoughtful and sensitive and he cared deeply about the families he worked with.

He was also a person of tremendous fun. I have fond memories of conference dinners where his humour, warmth, capacity to tell a good story and drink lots of beer always made it an entertaining evening. At the World Congress in Krems in July 2014, he was so full of life and fun; my abiding memory of him at that conference is of someone who was happy, laughing, loved his family and had so much to look forward to.

Photograph 4: Andrew O'Hanrahan and Hayley Hind in Krems, 2014

As both friend and colleague, Andrew was a wonderful listener and made everyone feel attended to and important. As his illness progressed he never lost hope or optimism and his determination in the face of his illness was quite something to witness. He retained an astonishing capacity to think about others and he continued to be passionate about music and his work.

Andrew lived his life passionately and generously and he will be hugely missed by the many people whose lives he touched.

Emily Corke

I worked with Andrew at Highfield School for just over a year and we shared the job of music therapist for the school. Although we were at the school on different days we met frequently to discuss our work. Andrew was encouraging and supportive and it was always a meeting full of laughter and joy. I remember going to a training day at Highfield and one of the speakers had to cancel with only an hour's notice. When the staff asked if anyone could fill in for that hour Andrew's hand shot up and volunteered to put on a music therapy presentation. Unlike Andrew who rose to the challenge, I shrunk back and asked him to take the lead. Andrew's ability to communicate the value of music therapy to others with ease and confidence, without needing time to prepare was a gift I greatly admired. He led a wonderful improvisation with staff and then presented some of his work. He was eloquent, confident and relaxed, and the staff greatly benefited from what Andrew shared, it was inspiring and impressive! It is clear that Andrew had great passion about music therapy and was driven by his compassion for the pupils. He was willing to take risks and was a great advocate for the profession. It was a joy to share the job of music therapist with Andrew at Highfield and he will be greatly missed not just by me but the pupils and staff at Highfield.

Photograph 5: In between presentations at the Krems Conference with Nicky Haire and Philippa Derrington

Ruth Oreschnick

It's hard to think about summing up such a vitally alive person as Andrew. He was a fantastic colleague, and a wonderfully humorous friend. As so many people said at his funeral - he had the knack of making you feel as though you mattered to him, that he valued your friendship and that you could have the most wonderful amount of fun together.

He carried a belief of people's innate worth into his music therapy work, trusting that the children and families in his sessions had something to give. And that music therapy could help them find a way to believe in their own capabilities. Somehow, with Andrew, the business of living became more alive.

Andrew was unpretentious. He was passionate, honest and able to talk about the more difficult

aspects of situations. He wasn't much interested in formalities - he was far too busy getting to know who someone really was, and engaging with that to let niceties get in the way.

He was also the most generously supportive of people. When I moved to India for work, he rang me up frequently to make sure that I was OK, to find out about Delhi: what was it like; how was the music therapy work going; was it colourful; what did it sound like? His patience during power cuts, and my sometimes irascible shouting at the temperamental telephone while he was on the other end of it were typical of his generosity and humour.

When Andrew became ill in April of last year, he talked about how much he missed being able to work as a music therapist, and how much it meant to him. He tried to keep working for as long as possible. His love of families, his own included, drove him to keep going and it was a blow when he finally had to stop. It was a testament to him that so many of his colleagues, friends and families of clients went to his funeral.

Photograph 6: Andrew in Jyväskylä, 2012

As I write this I imagine Andrew laughing and then saying – “for God's sake, Ruth – what about my punk band in the late 70's, the Rolling Stones, my wonderful children and family, whisky, floral shirts, Chopin...”. This list would go on for some time. As I said it's hard to sum up the very vitally alive essence of Andrew in words. Perhaps enough to say that it was a huge privilege to have been his friend, and to have shared in some of that vitality for a while.

Nicky Haire and Philippa Derrington

Andrew, along with so many others, we’ll miss many things about you but above all we’ll miss your cheeky smile and permanent twinkle, your hoarse laugh, your fun, your self-deprecating but sound, down-to-earth point of view, your joy in music therapy work, your brightly coloured shirts and slightly ruffled look, your lightness in challenging situations, your positive but realistic stance about difficult work, your generosity, charm, humour and lively, irreverent spirit.

Here’s to you.

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Μεταφρασμένες περιλήψεις

Translated abstracts

Μετάφραση στα ελληνικά: Δήμητρα Παπασταύρου

Το ταξίδι ενός προγράμματος κοινοτικής μουσικοθεραπείας

Bethan Lee Shrubsole

ΠΕΡΙΛΗΨΗ

Από την έναρξη του προσανατολισμένου στην κοινότητα μουσικοθεραπευτικού οργανισμού Music for Peaceful Minds (MPM) τον Ιούλιο του 2008, βρίσκονται εν εξελίξει σταδιακές αλλά σημαντικές αλλαγές σχετικά με τους τρόπους που ασκείται και συζητείται η μουσικοθεραπεία παγκοσμίως. Αυτές οι αλλαγές ταυτόχρονα έχουν θέσει ερωτήματα και έχουν ενημερώσει το τοπικό έργο του οργανισμού MPM στη βόρεια Ουγκάντα.

Το παρών άρθρο αποτελεί έναν προσωπικό αναστοχασμό αναφορικά με το έργο του MPM κατά τα τελευταία επτά χρόνια, με στόχο να εξηγήσει τη σημασία τού να δουλεύει κανείς ως μουσικοθεραπευτής με γνώμονα την κοινότητα, όταν εργάζεται σε μέρη όπου απατείται μια ευέλικτη προσέγγιση. Πώς αυτό το έργο έχει απομακρυνθεί από τη συμβατική μουσικοθεραπεία; (όπου τα συμπτώματα και τα προβλήματα υγείας σε ατομικό επίπεδο γίνονται το επίκεντρο της προσοχής εντός του θεραπευτικού πλαισίου) (Stige 2002). Και πώς έχει εξελιχθεί ο MPM κατά τη διάρκεια αυτών των χρόνων παράλληλα με τις αλλαγές του επαγγέλματος της μουσικοθεραπείας μετά την εμφάνιση της κοινοτικής μουσικοθεραπείας;

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

πλαστικότητα του εγκεφάλου, Ρυθμική Dalcroze, ενσωμάτωση, πολυ-αισθητηριοκινητική ενσωμάτωση, νευρολογική μουσικοθεραπεία, εγκεφαλικό επεισόδιο

Η **Bethan Lee Shrubsole** οργάνωσε το πρόγραμμα Music for Peaceful Minds (MPM) στη βόρεια Ουγκάντα το 2008 και έκτοτε εποπτεύει τους θεραπευτές του προγράμματος. Από το 2011 έως το 2015 εργάστηκε ως μουσικοθεραπεύτρια στη δυτική Ουγκάντα δουλεύοντας με παιδιά με αυτισμό, σύνδρομο Down και προβλήματα ακοής σε ένα κρατικό σχολείο. Σήμερα ζει στο Cambridge με το σύζυγό της και τους δύο γιους της και εργάζεται ως μουσικοθεραπεύτρια σε τοπικά σχολεία.

E-mail: musicforpeacefulminds@yahoo.co.uk

Διαμοιρασμός διαδραστικών θεραπευτικών μουσικών δεξιοτήτων στη Δυτική Όχθη: Μία έκθεση αξιολόγησης του προγράμματος Beit Sahour

Elizabeth Coombes & Michal Tombs-Katz

ΠΕΡΙΛΗΨΗ

Παρά τη συνεχή διάδοση των προγραμμάτων διαμοιρασμού διαδραστικών θεραπευτικών μουσικών δεξιοτήτων, η έρευνα είναι ελάχιστη σχετικά με τα κίνητρα των εκπαιδευόμενων και τη μεταφορά δεξιοτήτων, πτυχές που φαίνεται να είναι ζωτικής σημασίας για την επίτευξη των στόχων των προγράμματων ως προς την αναβάθμιση των δεξιοτήτων των εργαζομένων (εκπαιδευόμενων) και την ωφέλεια των πελατών. Το πρόγραμμα Beit Sahour (2012 - σε εξέλιξη) είχε ως στόχο να εξοπλίσει εκπαιδευτικούς και κοινωνικούς λειτουργούς με τις κατάλληλες δεξιότητες ώστε να οργανώσουν τέτοιες ομάδες στον εργασιακό τους χώρο. Αυτό το άρθρο παρέχει μια αξιολόγηση του προγράμματος που πραγματοποιήθηκε στη Δυτική Όχθη σε δύο σχολεία γενικής εκπαίδευσης, δίνοντας ιδιαίτερη έμφαση στα κίνητρα των εκπαιδευόμενων, την ποιότητα του προγράμματος κατάρτισης, και τη μετέπειτα χρήση και ενσωμάτωση των γνώσεων και των δεξιοτήτων. Για τους σκοπούς της αξιολόγησης, μια σειρά ερωτηματολογίων κατασκευάστηκε και χορηγήθηκε σε συγκεκριμένες χρονικές στιγμές κατά τη διάρκεια της εκπαίδευσης και μετά την ολοκλήρωσή της. Για την παροχή περισσότερων πληροφοριών σχετικά με τους τομείς της αξιολόγησης ζητήθηκαν εκθέσεις από τα σχολεία που συμμετείχαν. Το άρθρο προσφέρει μια συνολική σύνοψη των ευρημάτων, και διατυπώνει προτάσεις για τομείς μελλοντικής έρευνας σε προγράμματα αυτού του είδους.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

μουσική, θεραπευτικό, διαμοιρασμός δεξιοτήτων, σχολεία, κίνητρα μάθησης, οργανικότητα [instrumentality], μεταφορά, δεξιότητες

Η **Elizabeth Coombes** (BMus, MA) είναι πιστοποιημένη μουσικοθεραπεύτρια (HCPC), λέκτορας, μουσικός και διευθύντρια του μεταπτυχιακού προγράμματος μουσικοθεραπείας στο πανεπιστήμιο της Νότιας Ουαλίας στο Newport. Από την κατάρτισή της το 2000 και μετά, η Elizabeth έχει ειδικευτεί στην εργασία με παιδιά και νέους με συναισθηματικές και συμπεριφορικές δυσκολίες. Για να υποστηρίξει το έργο της χρησιμοποιεί την ψυχοδυναμική σκέψη και αξιοποιεί τη σημαντική εμπειρία της στη μουσική δημιουργία στην κοινότητα. Από το 2009 έχει εργαστεί σε διαδραστικά θεραπευτικά μουσικά προγράμματα στη Δυτική Όχθη, εστιάζοντας το ενδιαφέρον της στο πώς αυτές οι δεξιότητες όταν διαμοιράζονται σε επαγγελματίες που δεν είναι μουσικοί, όπως είναι οι εκπαιδευτικοί και οι κοινωνικοί λειτουργοί, μπορούν να εμπλουτίσουν την πρακτική τους.

Email: elizabeth.coombes@southwales.ac.uk

Η **Michal Tombs-Katz** (PhD στην Ψυχολογία, Cardiff University) είναι ψυχολόγος (AFBPsS) και έχει πιστοποίηση στην εργασιακή ψυχολογία (HCPC). Ως ειδική στον τομέα της εκμάθησης και της ανάπτυξης, η Michal χρησιμοποιεί ψυχολογικές αρχές για τη μελέτη φαινομένων που σχετίζονται με την εκμάθηση. Παρουσίασε το έργο της σχετικά με τα κίνητρα μάθησης σε εθνικό και διεθνές επίπεδο και σε επιστημονικά περιοδικά. Πιο πρόσφατα, έγραψε το κεφάλαιο ενός βιβλίου για την British Psychological Society με τίτλο «Προωθώντας μια κουλτούρα συνεχούς μάθησης στο εθνικό σύστημα υγείας: Ο ρόλος της ηγεσίας». Η Michal έχει εκτεταμένη εμπειρία διδασκαλίας στην τριτοβάθμια εκπαίδευση και είναι η υπεύθυνη των προπτυχιακών μαθημάτων των προγραμμάτων ψυχολογίας στο Πανεπιστήμιο της Νότιας Ουαλίας στο Newport.

Email: michal.tombs@southwales.ac.uk

Ένα ταξίδι ανακάλυψης: Από την εκπλήρωση κριτηρίων χρηματοδότησης στην εμφάνιση ενός σαφέστερου οράματος για τη μουσικοθεραπεία σ' ένα ειδικό σχολείο

Claire Cartwright

ΠΕΡΙΛΗΨΗ

Στην εποχή της ερευνητικά τεκμηριωμένης πρακτικής, οι μουσικοθεραπευτές καλούνται ολοένα και περισσότερο να προσκομίζουν αποδεικτικά στοιχεία στους χρηματοδότες τους. Συχνά, αυτό σχετίζεται με την απαίτηση για «αξιολόγηση των υφιστάμενων υπηρεσιών ή για τη δικαιολόγηση δημιουργίας νέων υπηρεσιών με τα 'κατάλληλα' τεκμήρια» (Pavlicevic, Ansdell, Procter & Hickey 2009: 3-4). Ο φορέας Youth Music Initiative | Creative Scotland (YMI) χρηματοδότησε τον μουσικοθεραπευτικό οργανισμό Nordoff-Robbins στην Σκωτία για να υποστηρίξει τις υπηρεσίες μουσικοθεραπείας σ' έναν αριθμό σχολείων μιας περιοχής τοπικής αυτοδιοίκησης στη Σκωτία. Ως μέρος της διαδικασίας χρηματοδότησης ο φορέας ζήτησε την αξιολόγηση της υπηρεσίας που προσφέρθηκε σ' ένα απ' αυτά τα σχολεία. Το πρώτο μέρος του παρόντος άρθρου περιγράφει την αξιολόγηση (που πραγματοποιήθηκε το 2013) της μουσικοθεραπευτικής υπηρεσίας σ' ένα σχολείο για μαθητές με σύνθετες ανάγκες. Η αξιολόγηση στόχευε στην εκτίμηση της επίδρασης που έχει η μουσικοθεραπεία στους μαθητές και στο σχολείο, και στη διασφάλιση της ποιότητας της υπηρεσίας. Το δεύτερο μέρος του άρθρου αναλύει τη διαδικασία αντιμετώπισης ενός επιπλέον αιτήματος που ανέξυψε από τους χρηματοδότες μετά την ολοκλήρωση της αξιολόγησης. Αυτή τη φορά, όλα τα σχολεία που χρηματοδοτήθηκαν από τον φορέα κλήθηκαν να παράσχουν πληροφορίες για ν' αποδείξουν ότι πληρούν τις προϋποθέσεις ώστε να διασφαλίσουν την ανανέωση της χρηματοδότησης. Οι μελέτες περίπτωσης και τα πορίσματα της αξιολόγησης χρησιμοποιούνται για να διευκρινιστεί ο τρόπος με τον οποίο η μουσικοθεραπεία ανταποκρίνεται στους στόχους του χρηματοδότη. Η διαδικασία αυτή οδήγησε στην ανάπτυξη ενός μοντέλου για τη συνεχή παροχή μουσικής στο σχολείο. Αυτό το άρθρο έχει ως στόχο ν' αναδείξει πώς αυτό το ταξίδι χρηματοδότησης δεν εξασφάλισε μόνο τη συνέχιση της μουσικοθεραπείας, αλλά στην πραγματικότητα είχε ως επακόλουθο ένα σαφέστερο όραμα για τον ρόλο της μουσικοθεραπείας στο σχολείο.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

μουσικοθεραπεία, χρηματοδότηση, όραμα, αξιολόγηση υπηρεσίας, μουσική παιδαγωγική, σύνθετες ανάγκες

Η **Claire Cartwright** κατάγεται από την Ιρλανδία. Παίζει πιάνο και κλαρινέτο και έχει διδάξει κλαρινέτο, φλογέρα και θεωρία της μουσικής σε δημοτικά σχολεία και σε μια ορχήστρα πνευστών, στην οποία διετέλεσε καλλιτεχνική διευθύντρια της Ορχήστρας Νέων. Η Claire ολοκλήρωσε τις προπτυχιακές της σπουδές στη μουσική (B. Mus.) το 2008 στο National University of Ireland, στο Maynooth. Στη συνέχεια απέκτησε το μεταπτυχιακό της (MSc) στη Nordoff-Robbins μουσικοθεραπεία από το Queen Margaret University στο Εδιμβούργο το 2011. Από τον Αύγουστο του 2011 η Claire συνεργάζεται στο μουσικοθεραπευτικό οργανισμό Nordoff-Robbins στην Σκωτία. Η κλινική της εμπειρία περιλαμβάνει παιδιά και ενήλικες με διαταραχές του αυτιστικού φάσματος, μαθησιακές δυσκολίες, προβλήματα ψυχικής υγείας και αισθητηριακές αναπηρίες.

Email: clairecartwright@nrscot.org.uk

Οι προκλήσεις της προώθησης και της διατήρησης της συνέχειας σε μια μουσικοθεραπευτική ομάδα για μητέρες και παιδιά που συναντιούνται κυρίως κατά τη διάρκεια των σχολικών διακοπών

Okiko Ishihara

ΠΕΡΙΛΗΨΗ

Αυτό το άρθρο διερευνά την έννοια της *συνέχειας* στο πλαίσιο μιας μακροπρόθεσμης ανοικτής μουσικοθεραπευτικής ομάδας για μητέρες και παιδιά μεταξύ 5 και 18 ετών με μαθησιακές δυσκολίες. Η ομάδα, που έχει τη βάση της σε ένα μικρό αγροτικό χωριό στην Ιαπωνία όπου στο παρελθόν δεν υπήρχε πρόσβαση στη μουσικοθεραπεία, είναι ενεργή εδώ και 13 χρόνια και συναντιέται κυρίως κατά τη διάρκεια των σχολικών διακοπών. Με την πάροδο του χρόνου, 27 γιαπωνέζες μητέρες με τα παιδιά τους έχουν συμμετάσχει στην ομάδα. Η θεραπεύτρια ενθαρρύνει τη μουσική αλληλεπίδραση και την έκφραση μέσω του μουσικού αυτοσχεδιασμού και της εργασίας με την οικογένεια.

Η σημασία της συνέχειας στη θεραπευτική πρακτική διερευνάται με διαφορετικούς τρόπους. Το άρθρο αυτό επικεντρώνεται σε μια μελέτη περίπτωσης ατομικής μουσικοθεραπείας με ένα παιδί στο αυτιστικό φάσμα (το οποίο συμμετείχε στην ομάδα), ενώ παράλληλα παρουσιάζει τα σχόλια των μητέρων που συμμετείχαν μαζί με τα παιδιά τους στην ομάδα. Επιπλέον, συζητιούνται οι θεωρίες και οι μέθοδοι που η μουσικοθεραπεύτρια θεώρησε χρήσιμες κατά τη δουλειά της με την ομάδα, όπως η μουσικοθεραπευτική προσέγγιση «επιστροφής στα βασικά» (Drake 2008) που βασίζεται στη θεωρία της προσκόλλησης (Bowlby 1988) και στα γραπτά του Winnicott (1960, 1963, 1971). Η έννοια της συνέχειας συζητείται αναφορικά με την ανάπτυξη ενός ασφαλούς περιβάλλοντος στην ομάδα όπου οι μητέρες και τα παιδιά επέστρεφαν συστηματικά. Προτείνεται ότι η διαδικασία ανάπτυξης αυτού του ασφαλούς περιβάλλοντος μπορεί με τη σειρά της να οδηγήσει σε μια μορφή γονεϊκής δικτύωσης που δύναται να υποστηρίξει παιδιά με μαθησιακές δυσκολίες καθ' όλη τη διάρκεια της ζωής τους.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

ομαδική μουσικοθεραπεία, παιδιά και οικογένεια, συνέχεια

Η **Okiko Ishihara** καταρτίστηκε ως μουσικοθεραπεύτρια το 2001 στο Guildhall School of Music and Drama και ολοκλήρωσε το μεταπτυχιακό της στο Anglia Ruskin University στο Ηνωμένο Βασίλειο. Επί του παρόντος, η Okiko εργάζεται με παιδιά με μαθησιακές δυσκολίες τόσο ιδιωτικά όσο και μέσα σε κοινότητες, καθώς και με ενήλικες σε υπηρεσίες ψυχικής υγείας στην Ιαπωνία. Δίνει επίσης διαλέξεις στο Πανεπιστήμιο Soai και στο Nara Medical University στην Ιαπωνία.

Email: Okikoishihara@gmail.com

Η μουσικοθεραπεία ως επάγγελμα στην Ισπανία: Παρελθόν, παρόν και μέλλον

Melissa Mercadal-Brotons, Patricia L. Sabbatella &
María Teresa Del Moral Marcos

ΠΕΡΙΛΗΨΗ

Η χρήση της μουσικής για θεραπευτικούς σκοπούς έχει μακρά ιστορία στην Ισπανία. Η κλινική πρακτική, η εκπαίδευση και η έρευνα που σχετίζεται με τη μουσικοθεραπεία είναι παρούσες στη χώρα εδώ και χρόνια. Αρκετοί άνθρωποι από διαφορετικές περιοχές της χώρας έχουν λειτουργήσει ως πρωτοπόροι, συνεισφέροντας με μεγάλη προσπάθεια και αφοσίωση στην εδραίωση αυτού του επαγγέλματος. Ωστόσο, ίσως επειδή αυτές οι πρωτοποριακές προσπάθειες στερούνταν ενότητας ή αποτύγχαναν ν' ακολουθήσουν παρόμοιες κατευθύνσεις, μένει ακόμη πολύς δρόμος μέχρι η μουσικοθεραπεία ως επιστημονικός τομέας και ως επάγγελμα να παγιωθεί και να ενσωματωθεί στα συστήματα εκπαίδευσης και υγείας και ν' αναγνωριστεί από τις αρμόδιες αρχές. Για να προχωρήσουμε προς αυτήν την κατεύθυνση, είναι σημαντικό και απαραίτητο να αναλύσουμε το πού βρίσκεται η μουσικοθεραπεία ως επάγγελμα επί του παρόντος, προκειμένου να εντοπιστούν οι πτυχές που εμποδίζουν την ανάπτυξη και την εδραίωσή της.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

μουσικοθεραπεία στην Ισπανία, επαγγελματοποίηση της μουσικοθεραπείας, διαπίστευση της μουσικοθεραπείας (μητρώο μουσικοθεραπείας), μουσικοθεραπευτική ανάπτυξη

Melissa Mercadal-Brotons, PhD, MT-BC, MTAE. Μουσικοθεραπεύτρια που ειδικεύεται στον τομέα της γεροντολογίας και της άνοιας. Μέλος της Ερευνητικής Ομάδας PSICOPERSONA (FPCCE-Blanquerna, URL). Διευθύντρια του μεταπτυχιακού προγράμματος στη μουσικοθεραπεία (Idec-UPF, Βαρκελώνη). Συντονίστρια ερευνητικών και μεταπτυχιακών προγραμμάτων (Escola Superior de Música de Catalunya -ESMUC) Εκπρόσωπος της Ευρωπαϊκής Συνομοσπονδίας Μουσικοθεραπείας EMTC στην Ισπανία. Πρόεδρος της επιτροπής εκδόσεων της Παγκόσμιας Ομοσπονδίας Μουσικοθεραπείας (WFMT).

Email: melissa.mercadal@esmuc.cat

Patricia L. Sabbatella, PhD, επόπτρια μουσικοθεραπείας (EMTR), MTAE. Επίκουρη καθηγήτρια στο University of Cadiz.. Διευθύντρια του προγράμματος μεταπτυχιακών σπουδών στη μουσικοθεραπεία. Εκπαιδευτικός, ερευνήτρια και θεραπεύτρια στον τομέα της μουσικοθεραπείας και της μουσικής εκπαίδευσης, με ιδιαίτερο ενδιαφέρον στην μουσική εκπαίδευση χωρίς αποκλεισμούς και στην ειδική αγωγή, στη μουσική ανάπτυξη και στην αξιολόγηση της μουσικοθεραπείας και στη μουσικοθεραπεία και ψυχική υγεία. Επικεφαλής ερευνήτρια του Ερευνητικού Ομίλου HUM-794: Μουσική & Κίνηση στην Εκπαίδευση και Θεραπεία (Ερευνητικό πρόγραμμα Ανδαλουσίας). Έχει υπηρετήσει σε επαγγελματικά συμβούλια της Παγκόσμιας Ομοσπονδίας Μουσικοθεραπείας (WFMT) και της Ευρωπαϊκής Συνομοσπονδίας Μουσικοθεραπείας (EMTC).

Email: laboratorio.musicoterapia@uca.es

Maria Teresa Del Moral Marcos, υποψήφια διδάκτορας, MTAE, μουσικοθεραπεύτρια (Escuela de Música y Danza 'Santa Cecilia), λέκτορας και συντονίστρια του μεταπτυχιακού προγράμματος μουσικοθεραπείας (Universidad de Salamanca Pontificia). Αντιπρόεδρος του Asociación Española de Musicoterapeutas Profesionales (AEMP).

Email: mtmoralma@upsa.es

Ματιές στις προκλήσεις και τις ευκαιρίες ενός νέου εκπαιδευτικού προγράμματος: Το μεταπτυχιακό πρόγραμμα μουσικοθεραπείας στο Πανεπιστήμιο της Νότιας Ουαλίας

Elizabeth Coombes

Μια συνέντευξη από την Ιωάννα Ετμεκτσόγλου

ΠΕΡΙΛΗΨΗ

Μπορεί να πει κανείς ότι η μουσικοθεραπευτική εκπαίδευση στο Ηνωμένο Βασίλειο έχει πλέον ωριμάσει δεδομένου ότι τα περισσότερα από τα τρέχοντα μεταπτυχιακά προγράμματα έχουν μια ιστορία διάρκειας μεγαλύτερης από μία δεκαετία. Το εκπαιδευτικό πρόγραμμα μουσικοθεραπείας που ξεκίνησε πρόσφατα στη Νότια Ουαλία φαίνεται να έχει ωφεληθεί από την υπάρχουσα εμπειρία των προηγούμενων προγραμμάτων σπουδών στο Ηνωμένο Βασίλειο, αλλά έπρεπε να λάβει υπ'όψιν του τα ιδιαίτερα χαρακτηριστικά του τόπου εντός του οποίου λειτουργεί. Σ' αυτήν τη συνέντευξη, η Elizabeth Coombes, η υπεύθυνη του μεταπτυχιακού προγράμματος σπουδών μουσικοθεραπείας του πανεπιστημίου της Νότιας Ουαλίας, μοιράζεται με τους αναγνώστες τού *Approaches* γεγονότα, αντιλήψεις και ηθικά ζητήματα που αφορούν το σχεδιασμό και την εφαρμογή του νέου αυτού προγράμματος σπουδών. Η συζήτηση της Elizabeth Coombes με την Ιωάννας Ετμεκτσόγλου που της πήρε συνέντευξη ακουμπά σε θέματα όπως είναι η προσαρμογή στα ιδιαίτερα τοπικά χαρακτηριστικά, οι απαραίτητες δεξιότητες των αιτούντων και η προσέγγιση της συνέντευξης, η ανάπτυξη των μουσικών δεξιοτήτων κατά τη διάρκεια του προγράμματος, η φύση και η διάρκεια της βιωματικής μουσικής ομάδας και της προσωπικής ψυχοθεραπείας, καθώς και οι συμβουλευτικές υπηρεσίες που παρέχονται από το πανεπιστήμιο. Επίσης, συζητιούνται η κλινική άσκηση και οι εργασιακές δυνατότητες που έχουν οι Βρετανοί απόφοιτοι και οι απόφοιτοι από άλλες χώρες. Καταλήγοντας στη συνέντευξή της, η Elizabeth Coombes παραθέτει κάποιες σκέψεις σχετικά με το κατά πόσο τα θέματα που αναπτύσσονται στην συνέντευξή της αφορούν και τους μουσικοθεραπευτές στην Ελλάδα.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

εκπαίδευση στη μουσικοθεραπεία, διαδικασία της συνέντευξης, εκπαίδευση μερικής απασχόλησης, δεξιότητες των υποψηφίων, προσωπική ψυχοθεραπεία, κλινική άσκηση, ιδιαίτερα τοπικά χαρακτηριστικά

Η **Elizabeth Coombes** (BMus, MA) είναι πιστοποιημένη μουσικοθεραπεύτρια (HCPC), λέκτορας, μουσικός και διευθύντρια του μεταπτυχιακού προγράμματος μουσικοθεραπείας στο πανεπιστήμιο της Νότιας Ουαλίας στο Newport. Από την κατάρτισή της το 2000 και μετά, η Elizabeth έχει ειδικευτεί στην εργασία με παιδιά και νέους με συναισθηματικές και συμπεριφορικές δυσκολίες. Για να υποστηρίξει το έργο της χρησιμοποιεί την ψυχοδυναμική σκέψη και αξιοποιεί τη σημαντική εμπειρία της στη μουσική δημιουργία στην κοινότητα. Από το 2009 έχει εργαστεί σε διαδραστικά θεραπευτικά μουσικά προγράμματα στη Δυτική Όχθη εστιάζοντας το ενδιαφέρον της στο πώς οι μουσικές δεξιότητες όταν διαμοιράζονται σε επαγγελματίες που δεν είναι μουσικοί, όπως είναι οι εκπαιδευτικοί και οι κοινωνικοί λειτουργοί, μπορούν να εμπλουτίσουν την πρακτική τους.

Email: elizabeth.coombes@southwales.ac.uk

Η **Ιωάννα Ετμεκτσόγλου** σπούδασε Μουσική Παιδαγωγική στο Πανεπιστήμιο του Illinois (Urbana, Η.Π.Α.) απ' όπου έλαβε το διδακτορικό της το 1992. Το 2000 εκπαιδεύτηκε ως μουσικοθεραπεύτρια στο Anglia Ruskin University (UK). Από το 1995 διδάσκει μαθήματα μουσικής ψυχολογίας, μουσικής παιδαγωγικής καθώς και εισαγωγικά μαθήματα στη μουσικοθεραπεία στο Τμήμα Μουσικών Σπουδών του Ιονίου Πανεπιστημίου στην Ελλάδα. Ενδιαφέρεται ιδιαίτερα για την προπαρασκευαστική εκπαίδευση στη μουσικοθεραπεία, για τη μουσική στην κοινότητα και για την ανάπτυξη του πολιτισμού και των φυσικοκεντρικών προσεγγίσεων της μουσικής μάθησης, οι οποίες δίνουν έμφαση στην προσωπική ανάπτυξη και στην κατανόηση και την αποδοχή της διαφορετικότητας.

Email: etioanna@ionio.gr

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