APPROACHES

An Interdisciplinary Journal of Music Therapy

Ένα Διεπιστημονικό Περιοδικό Μουσικοθεραπείας

www.approaches.gr

ISSN 2459-3338

15 (1) 2023

Approaches: An Interdisciplinary Journal of Music Therapy
15 (1) 2023

ISSN: 2459-3338 | www.approaches.gr

Editorial team

Hosted by Queen Margaret University and the Centre for Person-centred Practice Research.

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Approaches: An Interdisciplinary Journal of Music Therapy
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EDITORIAL

Invitations to gather

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Publication history:
Submitted 30 May 2023
Accepted 29 Jun 2023
First published 24 Jul 2023

A journal is more than a space where people present and read new knowledge. As authors share articles, reports, interviews, book reviews, conference reports, and letters and as we engage with these as readers across disciplines, theoretical perspectives, contexts and countries, we are in conversation with one another. When authors receive feedback from reviewers, when students discuss the content of a new article in their classroom, or when music therapists use the knowledge they glean from a new study in their sessions, they are part of an ongoing engagement not only with ideas but with each other. A journal is a place of gathering. In *The Art of Gathering*, Priya Parker (2018) explains that "we gather to solve problems we can't solve on our own […] We gather to make decisions. We gather because we need one another [...] We gather to honour and acknowledge" (p. 15). Careful reflection on how and why we gather is vital to optimising these experiences. Parker writes that if we do not explore the assumptions behind our gathering, we may simply replicate old, stale forms, and lose the possibility of birthing novel and transformative practices. Gatherings can hold warmth and heat. We welcome the warm ideas that affirm our practices, advocate for the value of our work, and celebrate the transformation that musicking affords. We also embrace the heat of critique and insightful questions as we challenge the status quo.

In this journal issue of *Approaches*, the concept of music and music therapy as a gathering space – a space to connect, to strive for personal and shared understanding, and to offer constructive critique – is represented in a number of interesting ways. Laura Teutsch, Sara Petrie and Heidi Ahonen use microanalysis and phenomenology to describe the different ways improvisational music psychotherapy provided a space for a client to build self-efficacy. Priya Shah and colleagues present group music therapy as a space to support people with eating disorders to express their emotions and explore their identity. Deborah Parker and colleagues consider the ways music therapy offered a space to transform the experience of toxic stress for four Palestinian refugee children living in Lebanon.

In their research, Fabian Joyce and Hillary Moss invite us to consider the way music therapists and community musicians share professional spaces in community contexts and offer insights to inform professional collaboration and cooperation. In her literature review, Mi Hyang Hwang explores interdisciplinary cooperation in a different way. She gathers together the discourse on music, music therapy and mindfulness from across the healthcare literature, and presents a comprehensive overview of current understanding of this topic. In response to Hwang's literature review, Jo Parsons offers a critical commentary, while this issue includes a number of book reviews and conference reports too reflecting on different kinds of gatherings of knowledge and professionals.

In diverse ways, these many authors contribute to our ongoing academic dialogue at *Approaches.* Into the future, we will continue to refine and reflect on the gathering place that is *Approaches*. And, in the words of Priya Parker, we will "reflect on our deeper assumptions" as we go; as we strive to maintain and evolve an inclusive, accessible, and informative space. We welcome you into this gathering space with us, and hope you enjoy this issue of *Approaches*.

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ΣΗΜΕΙΩΜΑ ΣΥΝΤΑΞΗΣ

Προσκλήσεις για συγκέντρωση

Andeline Dos Santos
University of Pretoria, Νότιος Αφρική

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ΒΙΟΓΡΑΦΙΕΣ ΣΥΓΓΡΑΦΕΩΝ
Η **Andeline dos Santos**, DMus, είναι επίκουρη καθηγήτρια μουσικοθεραπείας και συντονίστρια έρευνας στη Σχολή Τεχνών του University of Pretoria. Υπηρετεί ως συν-αρχισυντάκτρια του *Approaches*. [andeline.dossantos@up.ac.] Η Lucy Bolger είναι επίκουρη καθηγήτρια μουσικοθεραπείας στο Melbourne Conservatorium of Music, Αυστραλία. Υπηρετεί ως αναπληρώτρια συντάκτρια του Approaches. [bolger.l@unimelb.edu.au]

Ιστορία δημοσίευσης:
Υποβολή 30 Μάϊου 2023
Αποδοχή 29 Ιουν. 2023
Δημοσίευση 24 Ιουλ. 2023

Ένα περιοδικό είναι κάτι παραπάνω από ένας χώρος όπου οι άνθρωποι παρουσιάζουν και διαβάζουν νέες γνώσεις. Καθώς οι συγγραφείς μοιράζονται άρθρα, αναφορές, συνεντεύξεις, βιβλιοκριτικές, αναφορές συνεδρίων και επιστολές, και καθώς αλληλοεπιδρούμε με αυτά τα κείμενα ως αναγνώστες από διαφορετικούς επιστημονικούς κλάδους, θεωρητικές προοπτικές, πλαίσια και χώρες, συνομιλούμε μεταξύ μας. Όταν οι συγγραφείς λαμβάνουν ανατροφοδότηση από τους κριτές, όταν οι φοιτητές συζητούν το περιεχόμενο ενός νέου άρθρου στην τάξη τους ή όταν οι μουσικοθεραπευτές χρησιμοποιούν την γνώση που αποκομίζουν από μία νέα μελέτη στις συνεδρίες τους, γίνονται ο καθένας μέρος μιας διαρκούς εμπλοκής όχι μόνο με ιδέες, αλλά και του ενός με τον άλλο. Ένα περιοδικό είναι ένας τόπος συγκέντρωσης. Στο βιβλίο *The Art of Gathering* (Η Τέχνη της Συγκέντρωσης), η Priya Parker (2018) εξηγεί ότι «συγκεντρωνόμαστε μαζί για να επιλύσουμε προβλήματα που δεν μπορούμε να λύσουμε μόνοι μας [...] Συγκεντρωνόμαστε για να πάρουμε αποφάσεις. Συγκεντρωνόμαστε μαζί επειδή χρειαζόμαστε ο ένας τον άλλο [...] Συγκεντρωνόμαστε για να τιμήσουμε και να αναγνωρίσουμε» (σελ. 15, ελεύθερη μετάφραση). Ο προσεχτικός αναστοχασμός του πώς και γιατί συγκεντρωνόμαστε είναι σημαντικός για τη βελτιστοποίηση αυτών των εμπειριών. Η Parker γράφει ότι αν δεν εξετάσουμε τις υποθέσεις που βρίσκονται πίσω από τη συγκέντρωση, μπορεί απλά να αναπαραγάγουμε παλιές, ξεπερασμένες μορφές και να χάσουμε τη δυνατότητα γέννησης καινοτόμων και μεταμορφωτικών πρακτικών. Οι συγκεντρώσεις μπορούν να διατηρήσουν ζεστασιά και θερμότητα. Καλωσορίζουμε τις θερμές ιδέες που επιβεβαιώνουν τις πρακτικές μας, υποστηρίζουν την αξία του έργου μας και γιορτάζουμε την μεταμόρφωση που προσφέρει η μουσικοτροπία. Αγκαλιάζουμε ακόμη την ζεστασιά της κριτικής και των εύστοχων ερωτημάτων καθώς προκαλούμε το υφιστάμενο καθεστώς (status quo).

Σε αυτό το τεύχος του *Approaches*, η έννοια της μουσικής και της μουσικοθεραπείας ως χώρου συγκέντρωσης – ενός χώρου σύνδεσης, προσπάθειας για προσωπική και κοινή κατανόηση, και προσφοράς εποικοδομητικής κριτικής – απεικονίζεται με διάφορους ενδιαφέροντες τρόπους.

Οι Laura Teutsch, Sara Petrie και Heidi Ahonen χρησιμοποιούν τη μικροανάλυση και τη φαινομενολογία για να περιγράψουν τους ποικίλους τρόπους με τους οποίους η αυτοσχεδιαστική μουσική ψυχοθεραπεία πρόσφερε χώρο για την ανάπτυξη της αυτο-αποτελεσματικότητας ενός πελάτη. Η Priya Shah και οι συνεργάτες της παρουσιάζουν την ομαδική μουσικοθεραπεία ως έναν χώρο υποστήριξης ανθρώπων με διατροφικές διαταραχές για συναισθηματική έκφραση και εξερεύνηση της ταυτότητάς τους. Η Deborah Parker και οι συνεργάτες της εξετάζουν τους τρόπους με τους οποίους η μουσικοθεραπεία προσέφερε έναν χώρο μεταμόρφωσης της εμπειρίας του τοξικού στρες για τέσσερα παιδιά πρόσφυγες από την Παλαιστίνη που ζουν στο Λίβανο.

Στην έρευνά τους, οι Fabian Joyce και Hillary Moss μάς προτρέπουν να λάβουμε υπόψη τον τρόπο με τον οποίο οι μουσικοθεραπευτές και οι μουσικοί της κοινότητας μοιράζονται επαγγελματικούς χώρους σε κοινοτικά πλαίσια, και προσφέρουν ιδέες σχετικά με την επαγγελματική συνεργασία και σύμπραξη. Στην βιβλιογραφική της ανασκόπηση, η Mi Hyang εξετάζει τη διεπιστημονική συνεργασία από διαφορετική σκοπιά. Συγκεντρώνει τους διαλόγους σχετικά με τη μουσική, τη μουσικοθεραπεία και την ενσυνειδητότητα από τη βιβλιογραφία στον τομέα της υγείας και παρουσιάζει μια εκτενή επισκόπηση της τρέχουσας κατανόησης του θέματος. Ανταποκρινόμενη στη βιβλιογραφική ανασκόπηση της Hyang, η Jo Parsons προσφέρει έναν κριτικό σχολιασμό, ενώ παράλληλα αυτό το τεύχος περιλαμβάνει αρκετές κριτικές βιβλίων και αναφορές συνεδρίων που αντικατοπτρίζουν διάφορα είδη συγκεντρώσεων γνώσης και επαγγελματιών. Με διάφορους τρόπους, αυτοί οι πολλοί συγγραφείς συνεισφέρουν στον συνεχιζόμενο ακαδημαϊκό μας διάλογο στο *Approaches*. Στο μέλλον, θα συνεχίσουμε να βελτιώνουμε και να αναλογιζόμαστε τον χώρο συγκέντρωσης που είναι το *Approaches*. Και, με τα λόγια της Priya Parker, θα «στοχαζόμαστε τις βαθύτερες υποθέσεις μας» καθώς προχωρούμε, καθώς προσπαθούμε να διατηρήσουμε και να εξελίξουμε ένα συμπεριληπτικό, προσβάσιμο και ενημερωτικό χώρο. Σας καλωσορίζουμε σε αυτόν τον χώρο συγκέντρωσης και ελπίζουμε να απολαύσετε αυτό το τεύχος του *Approaches*.

ΒΙΒΛΙΟΓΡΑΦΙΑ

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ARTICLE

Utilising musical microanalysis and phenomenology to enhance understanding of the impact of improvisational music psychotherapy on self-efficacy for a client with depression and anxiety

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ABSTRACT

The purpose of this mixed methods study was to understand how a client's self-efficacy, defined as their perception of their own capability to achieve goals, is impacted by improvisational music psychotherapy conducted using MIDI instruments. Data was collected from session transcripts, several interviews with the client (Sara), and musical data. The musical microanalysis used the Music Therapy, MIDI, and MIR toolboxes within MATLAB. The collaborative data analysis incorporated the client's perspective. Results showed that the client's self-efficacy was influenced through multiple experiences within music psychotherapy including experiences of self-awareness and self-care; being confident and ready for change; growth and expansion outside of therapy; development and use of coping skills; and mastery and joy. By using musical microanalysis, results also indicated that certain musical features were linked to the client's imagery, mood states, and experiences of self-efficacy. The research gives an example of how to utilise musical microanalysis to enhance the understanding of therapeutic change and processes.

KEYWORDS

depression,
anxiety,
mental health,
self-efficacy,
music psychotherapy

Publication history:
Submitted 10 Aug 2020
Accepted 26 Apr 2021
First published 10 Aug 2021

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INTRODUCTION

The motivation for this study came from Laura's clinical music psychotherapy work with a client, Sara. As a clinical research team, we became curious about how and why her self-efficacy was changing within music psychotherapy. By conducting a study in which self-efficacy could be viewed through musical microanalysis, we hoped to understand what it looked like and sounded like in improvised music analysed with musical microanalysis. The research questions included: (1) How can music psychotherapy influence the self-efficacy of a client with anxiety and depression? (2) How can musical microanalysis enhance the understanding of therapeutic processes and change? (3) What is Sara's perspective on meaningful moments that influenced her self-efficacy during music psychotherapy improvisations? (4) What are the important features of improvisational music psychotherapy that contribute to the development of Sara's self-efficacy?

LITERATURE REVIEW

There is a dearth of literature covering the topic of the influence of music therapy or music psychotherapy on self-efficacy. The term is defined by Gallagher (2012) as "people's perceptions of their capability to execute the actions necessary to achieve a desired goal" (p. 314). Bandura suggests that self-efficacy has a significant impact on an individual's coping ability, particularly by promoting motivation (Bandura & Locke, 2003). According to Gallagher (2012), self-efficacy can be developed through five different mechanisms: "mastery experiences, modeling/vicarious experiences, imagined experiences, social persuasion, and somatic/emotional cues" (p. 315). Reeve (2015) similarly wrote about how self-efficacy is developed, discussing four experiences from which it can originate. These four, similar to Gallagher's five mechanisms, are: personal experiences of a particular task, observation of others' experiences with similar tasks, verbal persuasion from others, and one's physiological state.

While there is limited research on the effects of music psychotherapy on self-efficacy, there are studies indicating that other music activities have a positive effect on self-efficacy (Hohmann et al., 2017; Hovey, 2013; Yun & Kim, 2013). Hovey's (2013) study assessed how aesthetic therapy including musical activities influenced the self-efficacy of patients with schizophrenia. A parallel is drawn between the present study and Hovey's (2013) research in which it was noted that "those with higher levels of self-efficacy are likely to take on more challenging tasks" (p. NP3).

Self-esteem is similar to, though not exactly the same as, self-efficacy. Rolvsjord (2010) describes the difference between the two concepts, suggesting that "self-efficacy is concerned with judgments of personal capability, whereas self-esteem is concerned with judgments of self-worth" (p. 119). Branden (2006) wrote that self-esteem is "the disposition to experience oneself as being competent to cope with the basic challenges of life, and as being worthy of happiness" (p. 238). With these two definitions of self-esteem, it could be interpreted that self-efficacy is an element within self-esteem. Ryan and Deci (2017) wrote about two different types of self-esteem: contingent self-esteem, which fluctuates depending on whether one meets standards and expectations that have developed in the self; and true self-esteem, which is more stable and reliant on one's intrinsic sense of worth. One's contingent self-esteem, due to its fluid nature, would be easily influenced by experiences of mastery in music psychotherapy.

In various quantitative studies, music therapy has been shown to increase self-esteem in a variety of client populations, including academically stressed adolescents (Sharma & Jagdev, 2012), Chinese prisoners (Chen et al., 2016), and adolescents who have been sexually abused (Clendenon-Wallen, 1991). A qualitative study was used to demonstrate similar results in young adults with learning disabilities (Pavlicevic et al., 2014). Rolvsjord (2010) presented and analysed a case study in which music therapy was shown to contribute to the development of self-esteem in a young female client diagnosed with borderline personality disorder. Chang et al.'s (2018) research demonstrated that a music creation programme, in which participants created and performed meaningful music and songs, had a positive impact on the self-esteem of participants who had severe mental illness. It has also been indicated that a combination of creative arts therapies can be used to increase the self-esteem levels of college students (Yücesan & Şendurur, 2018). In a review of literature, Bungay and Vella-Burrows (2013) found that engagement in creative activities boosts self-esteem and confidence in young people.

Lawendowski and Bieleninik (2017) conducted a literature review of music therapy's influence on identity and self-esteem, and found that music therapy has a positive impact on both. A meta-synthesis of music therapy service users' experiences in mental health care, described that music therapy can aid in the development of identity, self-esteem, and self-confidence (Solli et al., 2013). Shin (2011) conducted a study to assess how participation in a particular music program influenced students' self-esteem. The results of this study showed that self-esteem was positively influenced by participating in the program and found four important factors that contributed to the development: the safety and positivity of the environment, encouragement from the music teachers, easy access to accomplishment, and the final performance. All four of these features can easily be translated into a therapy situation and could be taken into consideration when the therapist aims to bolster the self-esteem of a client, thereby also increasing the client's self-efficacy.

METHODOLOGY

The epistemological viewpoints of this abductive study were inspired by Van Manen's (1990) phenomenological inquiry in which the researcher can only know about the participant's lived experience through what the participant shares about the experience and through the researcher's observations. Data collected were approached with Van Manen's (1990) phenomenological lens in order to deeply understand Sara's rich, lived experience, and to enhance the depth of detail in the final interpretation of the qualitative data. A mixed-methods approach combining qualitative, phenomenological aspects of Sara's experience and quantitative, musical microanalysis was chosen to provide the most accurate analysis of musical qualities and self-efficacy while also staying true to Sara's perspectives and ideas. A convergent parallel design was used to collect and interpret the quantitative and qualitative data at the same time (Burns & Masko, 2016). By using both quantitative and qualitative research, this study is both empirically discovering data and creating new knowledge from the researcher's and participant's lived experiences.

Data collection

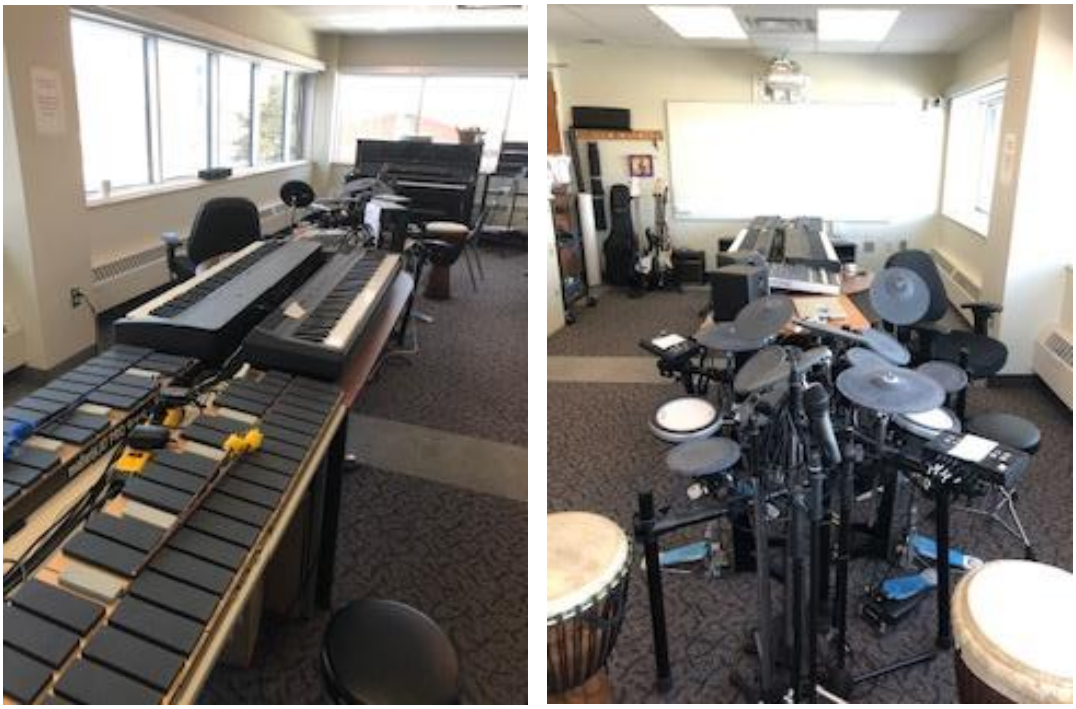
Sara was self-referred to Wilfrid Laurier University's music therapy clinic with Laura, the music therapist, because she was struggling with anxiety and depression and wanted to develop her self-confidence and become more comfortable in new situations. Therefore, these became the goals of the music psychotherapy process. After ten initial sessions, the clinical research team decided to conduct a case study based on her improvisational clinical work and ethical approval was granted by the Wilfrid Laurier University Research Ethics Board. During the sessions, integrative improvisational music psychotherapy (Erkkilä et al., 2011) was conducted, using a treatment plan developed specifically for Sara and aiming to achieve goals that were laid out by her and Laura together. Sessions often began with a verbal check-in to allow Sara to share anything which was important to her that had happened since the last session. Usually a theme for the session would arise from the check-in. Based on the theme, Laura and Sara began improvising. Sara would choose an instrument that she felt best represented the theme and would also choose an instrument for Laura to play which she felt would best complement her playing.

Data were collected through multiple methods. The improvisations were conducted using equipment in the Manfred and Penny Conrad Institute for Music Therapy Research Improvisation Laboratory. This included MalletKat instruments (digital xylophones) and MIDI keyboards. However, other acoustic and percussion instruments were also present in order to allow the therapeutic process to continue in a way that encouraged Sara to express herself anyway she wanted. However, Sara preferred to play the midi-instruments and djembe drums. Improvisations conducted on Improvisation Laboratory instruments were first recorded on the computer using Logic Pro software that provided audio recordings of improvisations, including the possibility to separately play back the therapist's and client's playing, generate notation of the music, and export the audio to various digital forms. Each of the sessions were video and audio recorded to provide another qualitative source of data. After each session, Laura, music psychotherapist, wrote detailed clinical notes regarding her own feelings, interpretations, and reflections about the session. The sessions were discussed with clinical supervisor, Linda Gambell and research supervisor, Heidi Ahonen. Upon completion of six sessions, Sara was engaged in an open-ended, in-depth interview about her experiences of music psychotherapy. Laura asked her to describe the meaningful moments she experienced within the therapy and to explain why they were significant to her. This interview was transcribed for ease of analysis. Based on this interview, four improvisations which were the most meaningful to Sara were selected for further investigation. After this Sara was asked to conduct an adapted version of Ferrara's (1984, 1991) analysis which will be described in detail in the next section. After this Sara, Laura, and Heidi met several times to discuss Sara's images and their meaning for her.

Data analysis and interpretation

Data from interviews, session transcripts, and session notes were analysed using phenomenological coding techniques, including the collection of themes, categories, and important quotes. Categories were found by indicating multiple quotes with similar topics or meanings. These categories were then collated to create more general themes. The finding of themes and categories relating to Sara's self-

efficacy and her music making was a vital aspect of the data analysis in order to understand the relationship between the two. This analysis involved a process of reflecting on the essential themes which characterised Sara's lived experience and observing each significant moment from multiple perspectives. Session notes, recordings, and interview/session transcripts were reviewed multiple times. As for the further analysis of the session and interview material, the research team chose four improvisations that were most relevant, meaningful, and significant for Sara's therapeutic process. The improvisations were chosen based on the discussion that came after the improvisations and their contribution to Sara's goal achievement. These improvisations were then listened to and analysed by Sara, utilising an adapted version of Ferrara's (1984, 1991) musical analysis technique (Ahonen & Houde, 2009).



Photograph 1: Equipment in the Manfred and Penny Conrad Institute of Music Therapy Research Laboratory

Open listening	Write down or draw your responses, including any impressions, feelings, images, body sensations.
Listening for semantic meaning	What is the mood? What is the atmosphere? How does it make you feel?
Listening for ontological meaning	What, as a composer are you saying with this music?
Open listening	What do you hear now after the four listenings? What are your thoughts and feelings? What is the meaning? What could be a title of this improvisation?

Table 1: Adapted from Ferrara 1984, 1991 by Heidi Ahonen for the purposes of this study

Sara was first asked to write down or draw her subjective responses, including any impressions, feelings, images, or body sensations. After that she was encouraged to describe the meaning of the music, such as its mood or atmosphere, and what the composer may have been trying to say with her music. In the end, she was asked to summarise her thoughts, for example, by giving the improvisation a title and theme.

As a result of Ferrara's analysis Sara generated more data and particular themes while describing her images, feelings and body sensations, stories, and drawings. When experiencing her imagery, Sara was able to express them using markers, pencil crayons, wax crayons, pen or pencil, and verbally (which the therapist would notate). Sara's themes were further discussed together in the research team meetings and explored through musical microanalysis which was conducted by utilising the Music Therapy Toolbox (Erkkilä, 2007; Erkkilä et al., 2004), MIDI toolbox (Eerola & Toiviainen, 2016), and MIR toolbox (Lartillot, 2019) within MATLAB. The purpose of microanalysis was to investigate if and how the most significant elements of Sara's most important themes were also visible in the improvised music, and if musical analysis could enhance the understanding of therapeutic change and therapeutic processes. By analysing musical elements including pitch, rhythm, and dynamics within both the therapist's and Sara's music, the research team could observe features of the therapeutic relationship and musical dialogues, as well as changes across time in Sara's music.

The following results first introduce descriptions of Sara's images, the musical microanalysis of the improvisations, and the clinical significance of each. The results section is followed by Discussion and Integration in which the characteristics of the descriptive phenomenological therapeutic process are integrated with musical analysis.

RESULTS

Image 1 – "The battles of give and take"

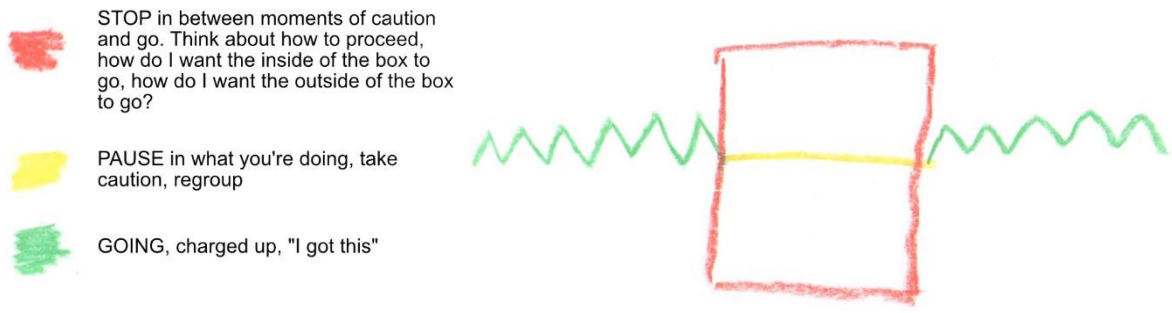


Image 1: Sara's imagery of a moment in improvisation #1

While listening to the recording of this first improvisation, Sara described her imagery and the feelings that went along with it in the following way:

> It would be like that outside of the box thing where you're feeling tension and you don't know if you really want to do it but then you also feel like you want to take the leap of faith and give it a try. You have a little tension with you because you're not sure how it's going to go but then when you give it a try you're like 'oh that wasn't so bad' and you're releasing the tension. It's kind of like that give and take thing.

While creating this image, during Ferrara's analysis, Sara emphasised the significance of the traffic light colours; each one held particular meaning. The red rectangle represented the "outside the box" concept of which Sara frequently spoke. While inside it, she could go slow, take caution, and breathe deeply, as represented by the yellow line. The green jagged line represented the moments Sara pushed herself to be outside her box, trying new things that she felt less comfortable with and the following realisation that it was not "so bad". This image was derived from a moment in the improvisation in which there was a brief silence. Sara felt that this silence was a safe zone in which she stepped back into her box to regain control before emerging again into less familiar territory. While the image was drawn based on one brief moment of the improvisation, Sara's give and take imagery was representative of the overall listening experience.

Musical analysis – Therapeutic relationship

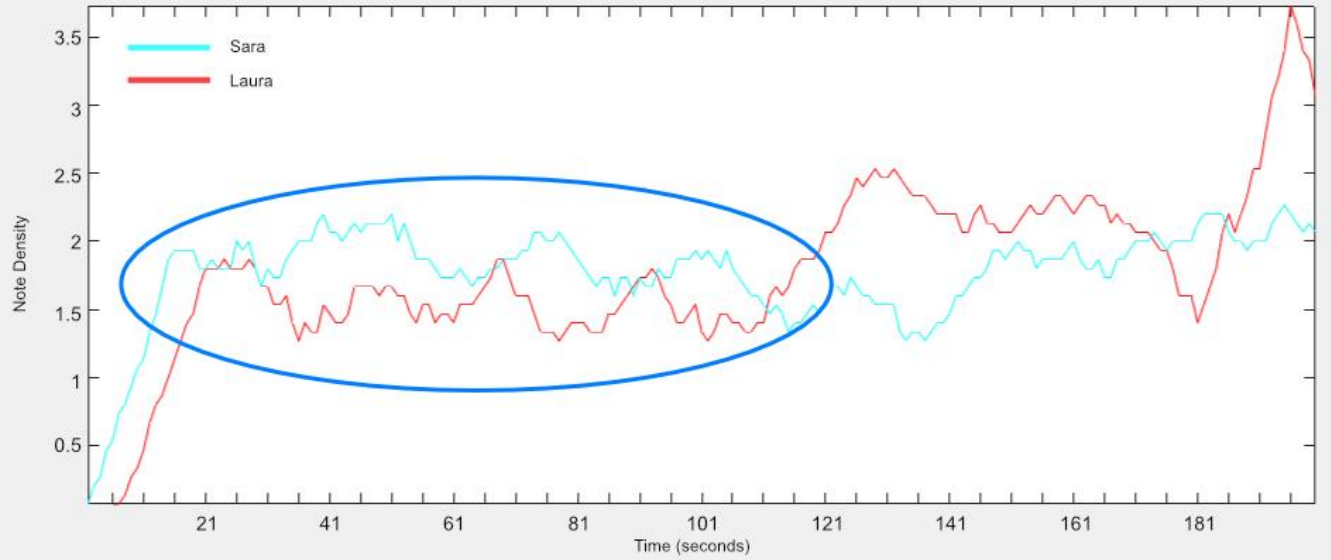


Figure 1: Note density in improvisation #1

One can see clearly in Figure 1 that there is dialogue, communication, and connection between therapist (red) and client (blue) as the two lines demonstrate similar but offset undulating patterns. Perhaps this is the give and take connection that Sara references in the title that she gave to the improvisation. This experience of connection, dialogue, and communication between therapist and client suggests an experience of social persuasion in which "the encouragement or discouragement of others can help shape our beliefs about our capabilities" (Gallagher, 2012, p. 316). The therapist uses the musical dialogue to encourage Sara to explore and try new things, to step out of her box.

Sara's imagery of being inside or outside of the box appears to correspond with her desire to become more comfortable in new situations, a recurrent theme of her therapeutic process, and an important element of her self-efficacy.

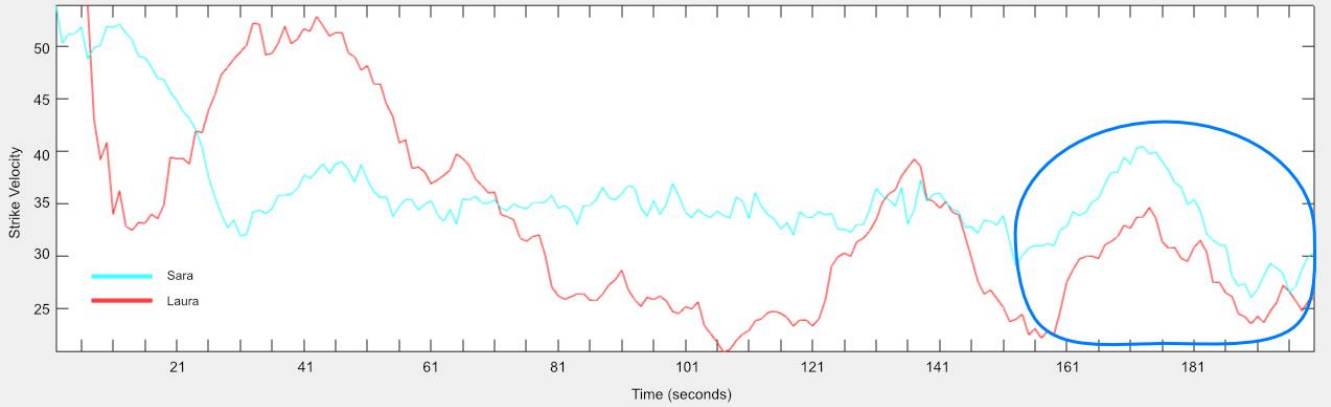


Figure 2: Mean velocity in improvisation #1

In Figure 2, one can see that Laura (red) follows Sara (blue) as she leads an increase in dynamics and then Sara follows as Laura leads a decrease in dynamic level. This happens at the end of the improvisation and prior to that there appeared to be a lack of connection in velocity (the strength with which the mallet struck the marimba key or the finger pressed the piano key) as Laura varied her dynamics throughout and Sara did not respond, staying relatively stable. It could be that once Sara became free enough after having tried "something and realised it's good", she felt safe now to explore and to form that connection with the therapist. According to Gallagher (2012) experiences of mastery are one of the most effective methods for the development of self-efficacy. Sara's image in which she overcame a fear of trying something new and successfully completed a task indicates an experience of mastery which would in turn boost her self-efficacy. Perhaps the dialogue that occurred earlier in the improvisation in the density window (Figure 1) allowed Sara to feel secure enough to try something new with velocity, thus contributing to her experience of mastery.

Musical analysis – Musical elements

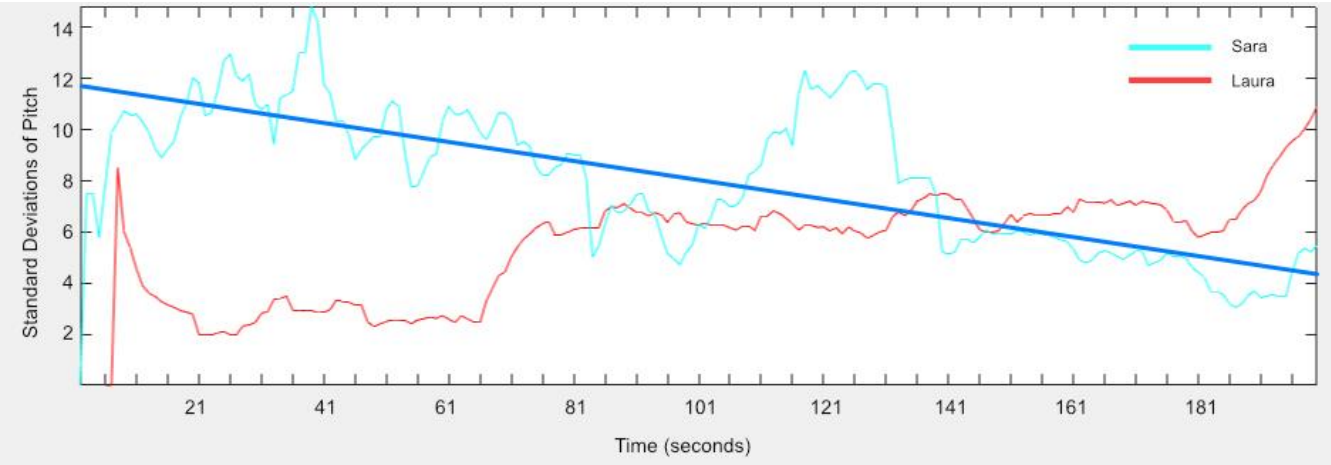


Figure 3: Pitch variance in improvisation #1

One can see that the variability of pitch (Figure 3) starts relatively high and overall decreases throughout the improvisation. According to Snape (2019), "the more agitated and nervous a participant felt, the wider the pitch range they used whilst improvising" (p. 147). Based on Snape's findings, Sara's decrease in pitch variance could suggest a decrease in tension as she became more comfortable and confident in the situation. These physiological cues are also thought to contribute to a sense of efficacy or inefficacy, as tension and discomfort can influence a person's beliefs about their own ability to achieve certain tasks (Gallagher, 2012; Reeve, 2015). Sara experienced those same somatic cues while listening to the recording of her own improvisation. She described feeling aching muscles along with tension and release. Sara's tension, illustrated by pitch variance, gradually decreased throughout the dialogue referenced in Figure 1 and then increased significantly at the time when that form of dialogue ended around 116 seconds. As Sara finds that the particular dialogue has come to an end, this loss of connection increased her anxiety and pitch variance. Sara quickly became comfortable in the new situation and her overall pitch variance continued to decrease.

In her description of her imagery for this improvisation, Sara discussed communication skills, which, when she believes in her ability to use them effectively, are an important part of her self-efficacy. She said,

> Communication is going so well, and then maybe it stops going so well and you have to work through it to get it to be better again. Communication is a really good word and you have to have communication. If you communicate better with someone, you're obviously going to have a better outcome than if you don't. You can have music therapy to work on your goals in the communication area to then maybe put your communication skills into use outside of music therapy.

Image 2 – "Life adventures in a storm"

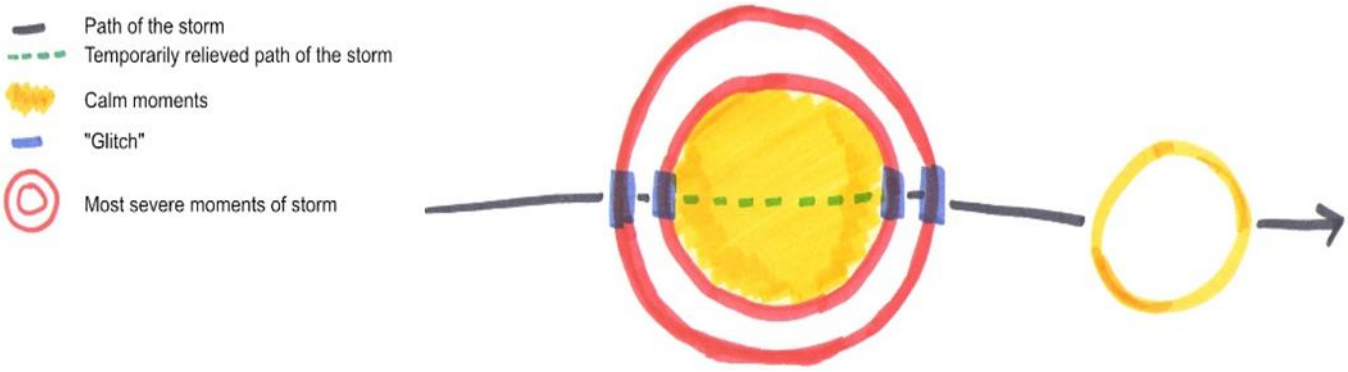


Image 2: Sara's imagery of improvisation #5

While listening back to this recorded improvisation, Sara described the image of a storm, during which her anxiety rose, her mood changed, her heart raced, and her breathing became heavier. The storm travelled along a path and could be seen to have multiple distinct areas. In the centre or the "eye" of the storm there was a sense of calm where the storm abated, surrounding the eye was the most severe portion of the storm where anxiety was highest. In Image 2, one can see the blue lines which are described as "glitches". Sara described these moments as the occurrence of an event, emotion, or

coping skill which would trigger a change for the worse or for the better.

Sara described the onset of a storm in the following way:

> I know something's happening in my body, but maybe I need to pinpoint more of how my body feels and the symptoms of when it's coming. Instead of 'wham, it's here', noticing signals in the body that says the storm is coming.

In this instance, Sara described the phenomenon discussed by Reeve (2015) who wrote that "an abnormal physiological state is a private, yet attention-getting, message that contributes to one's sense of inefficacy" (p. 275). Sara began to understand that her physiological state could influence her perceived ability to cope with difficult situations, such as storms. Music psychotherapy assisted Sara in understanding what signals her body was sending to her and knowing what this meant for her self-efficacy.

Musical analysis – Therapeutic relationship

Using MATLAB, very little was found in the way of musical connection between therapist and client in this improvisation. In this case it is considered apparent that Sara was likely displaying the kind of musical expression described by Jackson (2013) who wrote that depressed and anxious clients "may exhibit difficulty in musically interacting with others, and may only mimic others' playing, or even play in a manner that is completely disconnected and unresponsive to others" (p. 340). In this improvisation, Sara described being in a storm during which her anxiety is at its highest. In describing the storm Sara suggested that it "goes with the anxiety and the depression where it's kind of fearful and you feel alone". When storms occur, Sara feels that she wants to close herself in her basement or sleep through it, both being situations in which she would be alone and isolated. Perhaps the lack of musical connection between Sara and Laura is representative of the aloneness that Sara feels during literal and metaphorical storms.

Musical analysis – Musical elements

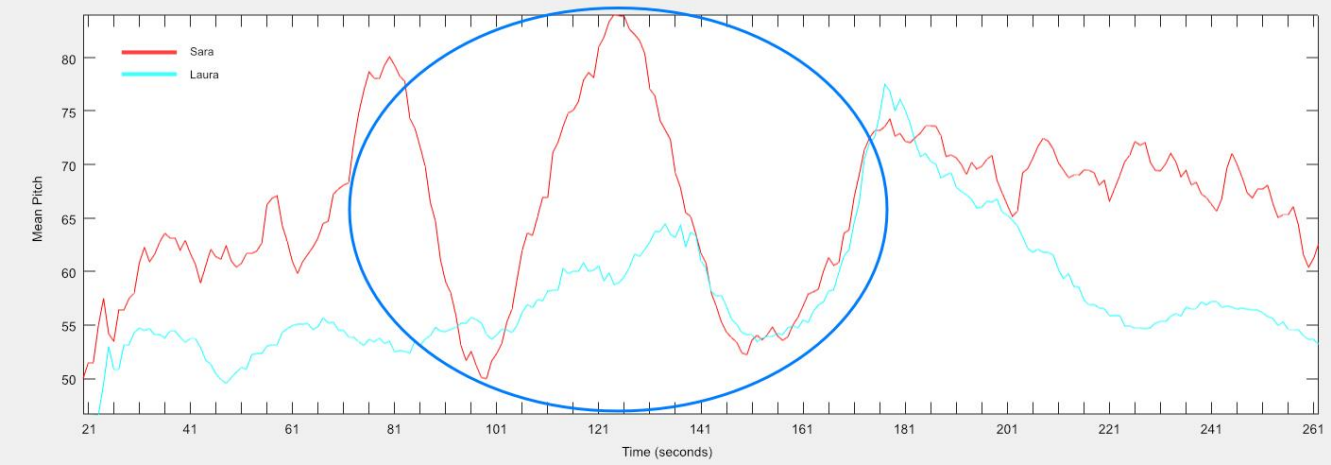


Figure 4: Mean pitch in improvisation #5

While listening to this recording, Sara described higher pitch notes as instilling calm and happiness, and low notes as being representative of dark grey colours and gloomy feelings. This interpretation of the meaning of various pitch ranges is supported by Snape's (2019) findings which suggest that "when depressed clients improvised, if they felt sad they played lower, darker notes, […] when they felt affectionate, they played higher, brighter notes" (pp. 149-150). In her image, the storm passes through two particularly severe moments with a period of calm in between them. In Figure 4 one can see that there are two particularly low valleys, representing lower average pitch, with a significantly high peak in between them – the eye of the storm.

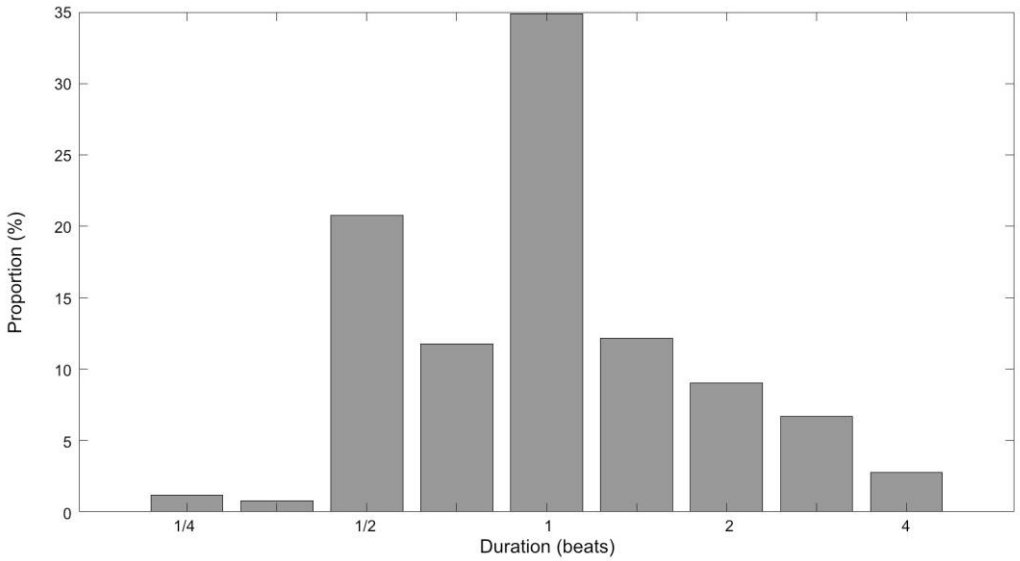


Figure 5: Distribution of note durations in improvisation #5

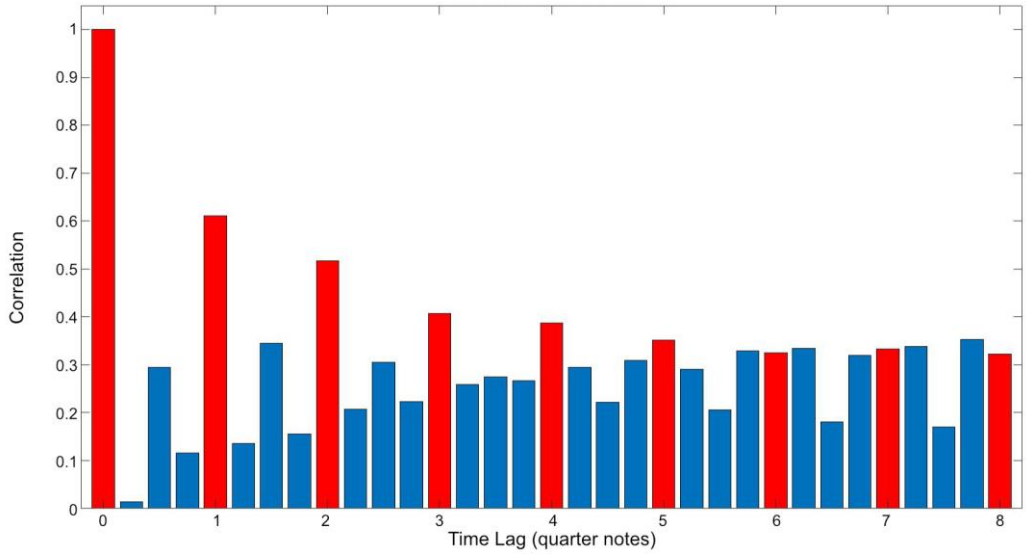


Figure 6: Autocorrelation of onset times in improvisation #5

In Figure 5 one can see that Sara played proportionally more quarter notes and eighth notes than other note durations. (Quarter notes and eighth notes were used as the measure of rhythm based on the capabilities of the MIDI toolbox software.) This indicates a steady pulse and a sense of security in

rhythm. In Figure 6 one can see that the onset of Sara's notes fell predominantly on the beat (represented by the red bars) and on off-beats (represented by the middle of the blue bars) as determined by the software. The fact that this trend begins to become less clear around 5 quarter notes could indicate that although Sara played a steady repeating pulse, it was not a consistent tempo, perhaps gradually slowing or speeding up. Sara's steady rhythmic pattern including quarter notes and eighth notes could be seen as indicative of her mood state as, according to Snape (2019) "depressed participants tended to play in a more stable rhythm than healthy participants when they were describing their current feelings" (p. 38). Kenneth Bruscia (1987) made an interpretation as to why this may be the case, suggesting that

> pulse gives security, stability, predictability, and a reassurance that instinctual forces or energy will not become overwhelming or disappear. The pulse provides a 'ground' that holds, supports, controls, and equalizes energy and drives. In doing so, pulse serves to ward off primal anxiety and fears of overstimulation. (Bruscia, 1987, p. 451)

In Sara's case, a storm is a time in which primal anxiety tends to dominate, and so by playing with a steady pulse she was remaining in a place of security and stability, ensuring that she will not be overwhelmed by fear and anxiety.

Image 3 – "Love wins in miracles"

Image 3: Sara's imagery of improvisation #6

While listening to this recording, Sara described feelings which reminded her of the death of her grandmother. Sara's grandmother passed away a few weeks before this session and coping with her grief became a significant part of the therapeutic process. This recording returned Sara to many of the same feelings she was experiencing at the time of its creation. Sara experienced several negative emotions, typical of people suffering a loss, including sadness, anxiety, confusion, exhaustion, frustration, speechlessness, and loneliness. She also experienced some positive emotions while listening and working through her grief, including togetherness, pride, determination, support, and focus.

Musical analysis – Therapeutic relationship

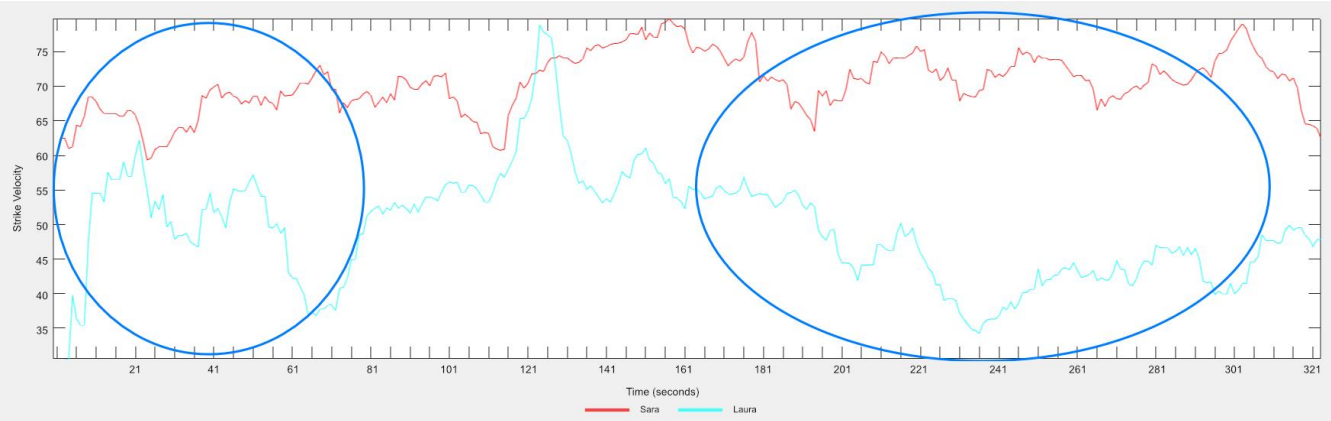


Figure 7: Mean velocity in improvisation #6

In Figure 7, Sara's music is represented by the red line and Laura's music is represented by the blue line. When observing how the two lines of music interact with each other, one can interpret the relationship between the two musicians. One can see in the two circled areas that both lines are following similar contours, seeing peaks and valleys occurring between them simultaneously. This indicates a significant level of connection between therapist and client, particularly because it is difficult to tell who is leading each of the changes in velocity. It is not simply that one is imitating the other; there is two-sided dialogue and connection. Rolvsjord (2010) discussed the importance of relational aspects when it comes to the development of self-efficacy. She wrote that "together with others it is possible to reach into the zone of proximal development and to develop and achieve better than you thought you could" (p. 118).

These two particular instances may be the moments in which Sara felt the positive feelings of support and togetherness.

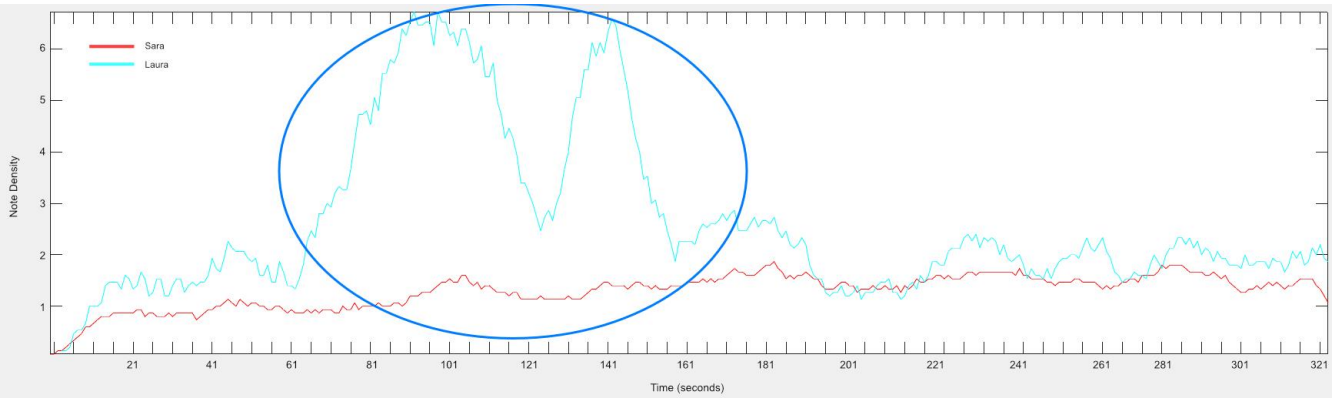


Figure 8: Note density in improvisation #6

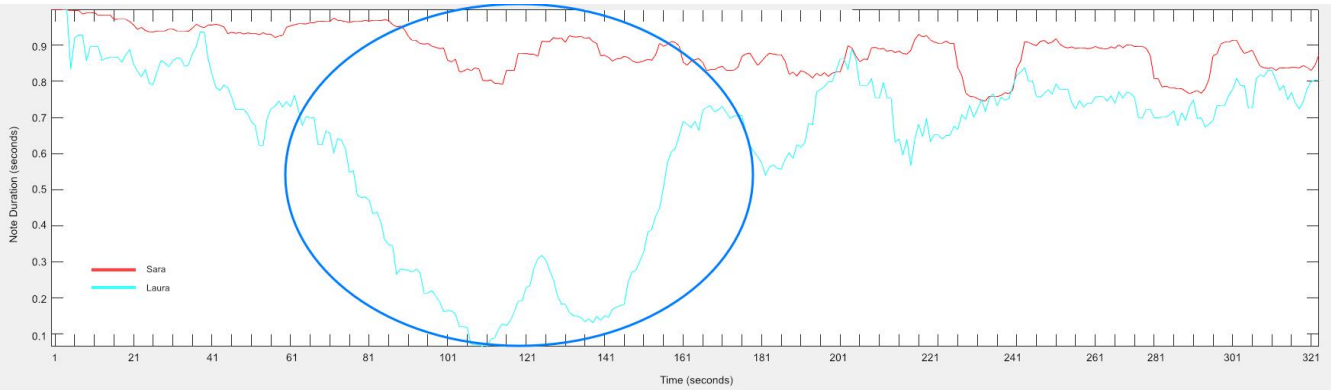


Figure 9: Mean note duration in improvisation #6

In Figures 8 and 9, Laura's music (blue) goes to extremes and Sara (red) follows with only very minor changes in the density and mean duration of her music. Gallagher (2012) suggested that modelling is one way that an individual can develop self-efficacy. By observing the changes that others are able to make, one's beliefs about one's own ability to make similar changes is influenced. In this case density and duration were both very stable traits in Sara's music and drastic change in rhythmic style was considered an unfamiliar task. The observation of Laura's changes allowed Sara to attempt change in her own music.

Musical analysis – Musical elements

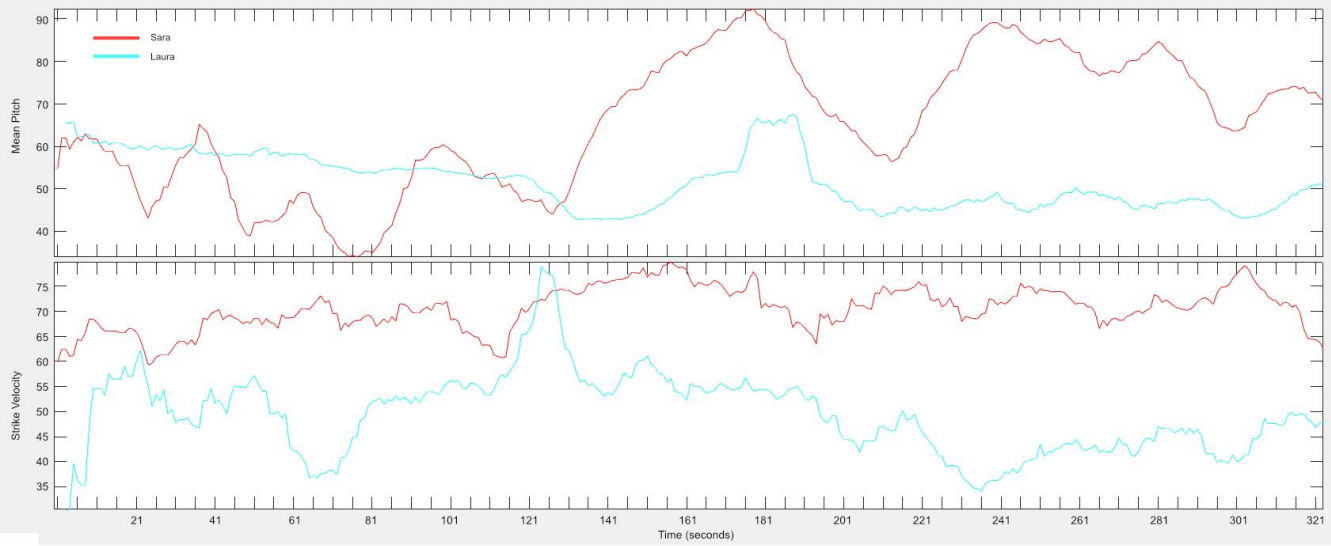


Figure 10: Mean pitch and mean velocity in improvisation #6

It can be seen in Figure 10 that Sara's mean pitch and velocity (red) follow a similar contour, although the variation in the mean velocity is significantly reduced in amplitude. Bruscia (1987) suggests that volume "can symbolize force, power, strength, size, and commitment" (p. 454). With this interpretation combined with Snape's (2019) findings that mean pitch can represent a person's mood state, it could be understood that when Sara's pitch is low and her mood state is sadder, she would be more quiet and timid, feeling less power and strength; and when her pitch is higher, her mood state

happier, her self-efficacy would be higher and therefore beliefs in her own force and commitment would also increase. Of course, this is not necessarily the case with all clients.

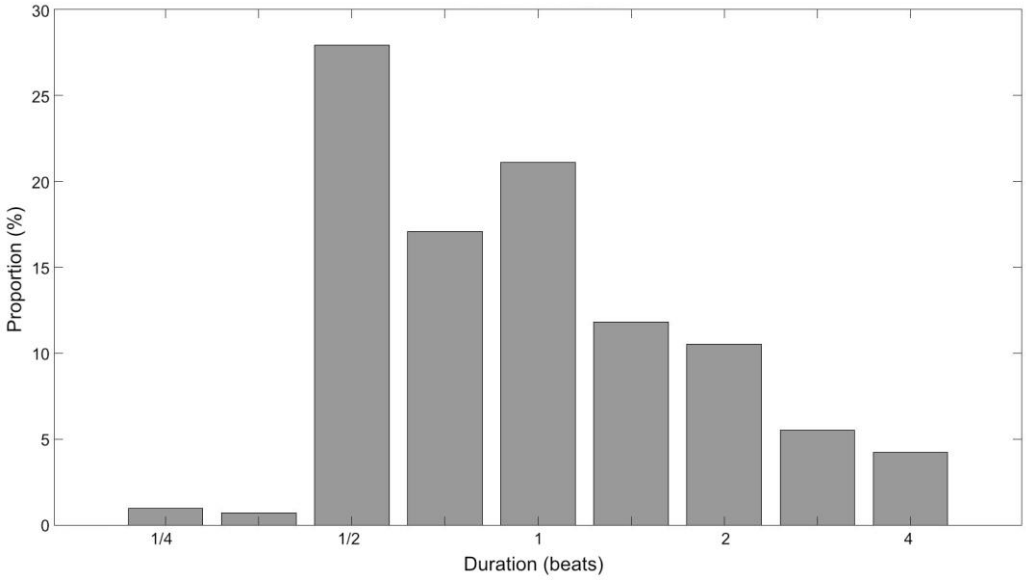


Figure 11: Distribution of note duration in improvisation #6

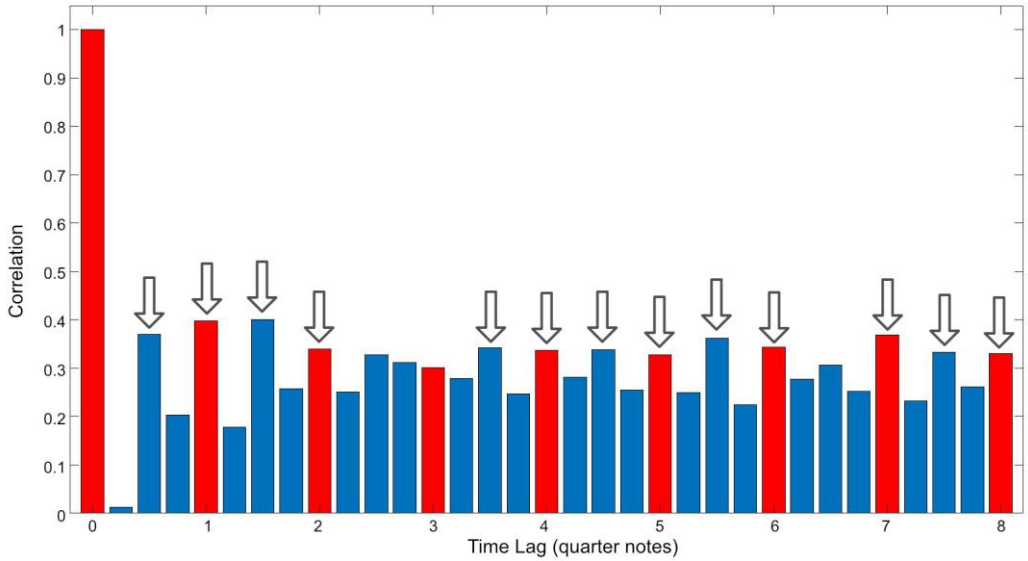


Figure 12: Autocorrelation of onset times in improvisation #6

Rhythm was an important musical element in Sara's music, and Bruscia (1987) wrote about the significance of sameness in rhythm:

> Keeping what one has, and not accepting every change or new idea that comes along builds a secure foundation for the present and a clear direction for the future. However, when sameness is preserved rigidly and urgently, there is no security in the present and no direction for the future. (Bruscia, 1987, p. 432)

Sara's rhythmic sameness was a key feature of the therapeutic process. In the beginning stages, she played the same rhythmic patterns repeatedly throughout improvisations and over time. This sameness verged on rigid and urgent, a lack of confidence in her ability to explore change and a desperate need to feel secure in the present. As Sara's therapy process continued, her sameness gradually shifted, beginning to find balance and change.

While listening to this improvisation, Sara thought about the loss of her grandmother. When coping with a loss so significant, it is important to feel grounded and secure in the present moment, which Sara allowed herself to feel by creating a steadying rhythmic pulse. With Bruscia's ideas in mind it can also be seen that by holding on to her steady pulse and not changing it, Sara developed an image of the future, looking towards coping mechanisms that she can use to navigate her way through a time of grief and loss.

Image 4 – "Life's magical processes"

Image 4: Sara's imagery of improvisation #7

As I go into the happy place, I'm by myself trying to regroup but as I get more comfortable I allow others into it or allow myself to try new things. I'm lying by the pond, finished lunch, relaxed. I put my feet in the pond. Next time I'm more confident to go a bit deeper, and eventually I'm comfortable enough to swim and move to the fountain to let it shower over me like washing the bad stuff away and then I can swim which has good vibes. I feel like a different person when I leave this meadow place than when I came to it. Each time I go to the meadow

> and each time I leave the meadow it's that much easier to deal with and handle situations and achieve the things I'm trying to accomplish.
>
> This image is like my happy place. When I'm going through the storm or a difficult place is coming, I know that I can reach to this place. Like a light at the end of the tunnel. I always know that this is available to me.

This image, which was created by a graphic artist during the data analysis phase according to Sara's detailed instructions about her imagery, could also be interpreted to represent the entire therapeutic process. Sara described a process in which she gradually submerges herself deeper into the pond, and entering and leaving the meadow. The meadow could be representative of the therapy environment and each time she leaves a therapy session "it's that much easier to deal with and handle situations and achieve the things I'm trying to accomplish". The pond could be representative of her personal experiences as she digs deeper and deeper into them, exploring emotions, feelings, struggles, and successes which will all allow her to achieve her therapeutic goals. Eventually she will reach the source (the fountain) and will be able to release herself from the things that are holding her back.

Musical analysis – Therapeutic relationship

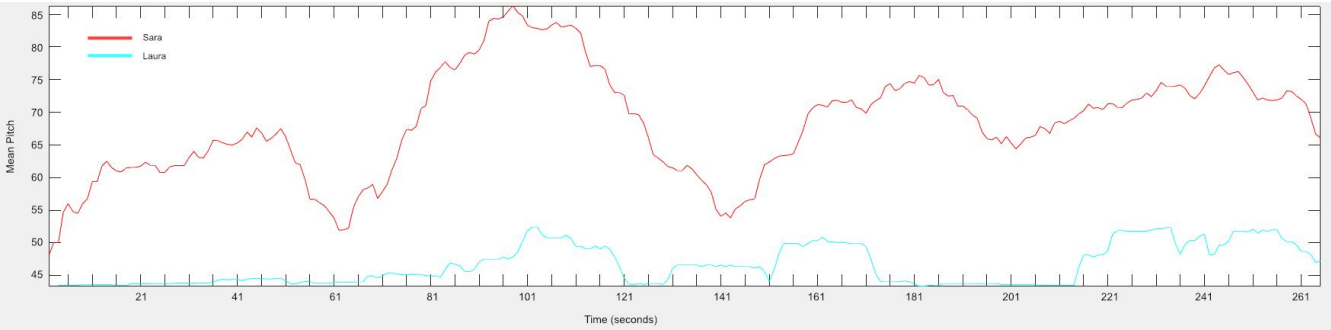


Figure 13: Mean pitch in improvisation #7

Improvisation "provides a means of establishing contact with another person, identifying with him/her, experiencing empathy, exchanging ideas, and sharing feelings" (Bruscia, 1987, p. 560). This type of relationship is clear when looking at the mean pitch of improvisation #7 (Figure 13) as Laura's and Sara's music follow the same contour, changing and adjusting with each other; leading, following, and communicating. In this case, Sara's image was one in which she enters her happy place and emerges in a different state, feeling more confident in her abilities to cope with difficult situations and to achieve her personal goals. She gradually allows other people to enter her oasis, suggesting an increase in self-efficacy and the building and strengthening of relationships such as this one.

Musical analysis – Musical elements

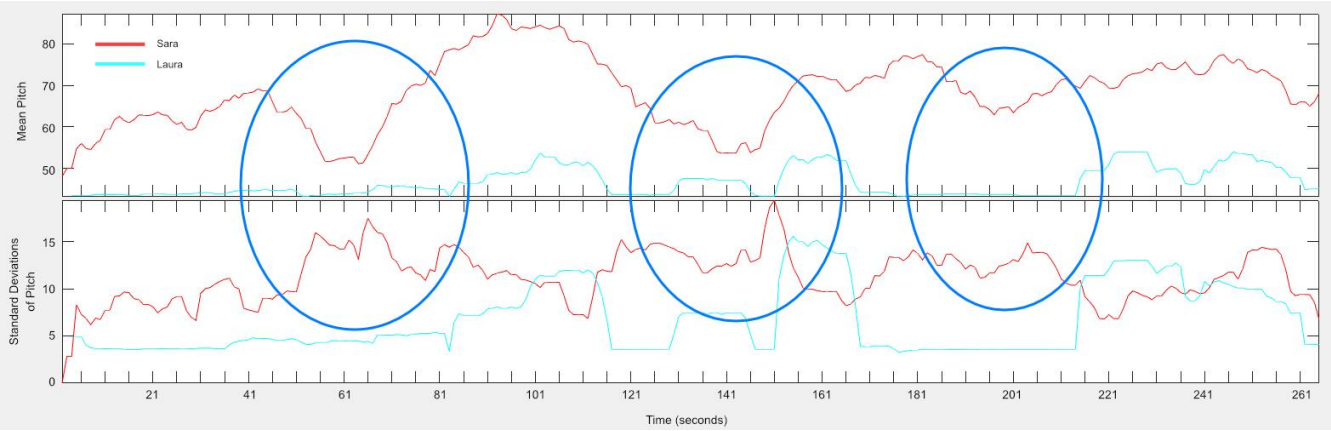


Figure 14: Mean and standard deviation of pitch in improvisation #7

When observing mean pitch and pitch standard deviation or range together, one can see that as mean pitch decreases, pitch range rises and vice versa. There are three moments in particular where this was the case, indicated in the circled areas of Figure 14. Based on Snape's (2019) findings which suggest that low average pitch is representative of sadness and wide pitch range is indicative of tension, we wonder if these were three moments in which Sara's tension and sadness were heightened. This also correlates to her image as she described gradually walking deeper into the pond in the middle of the meadow. As she wades deeper into the pond, her anxiety becomes more pronounced, however each time she enters the pond and returns to shore, she becomes more confident in her ability, her self-efficacy is slightly increased. One's knowledge of one's own experiences with a particular task is one of many factors that can influence self-efficacy (Gallagher, 2012; Reeve, 2015). In this case, as Sara successfully enters the pond and copes with the anxiety it induces, her own ability to cope becomes clearer to her, thereby increasing her self-efficacy.

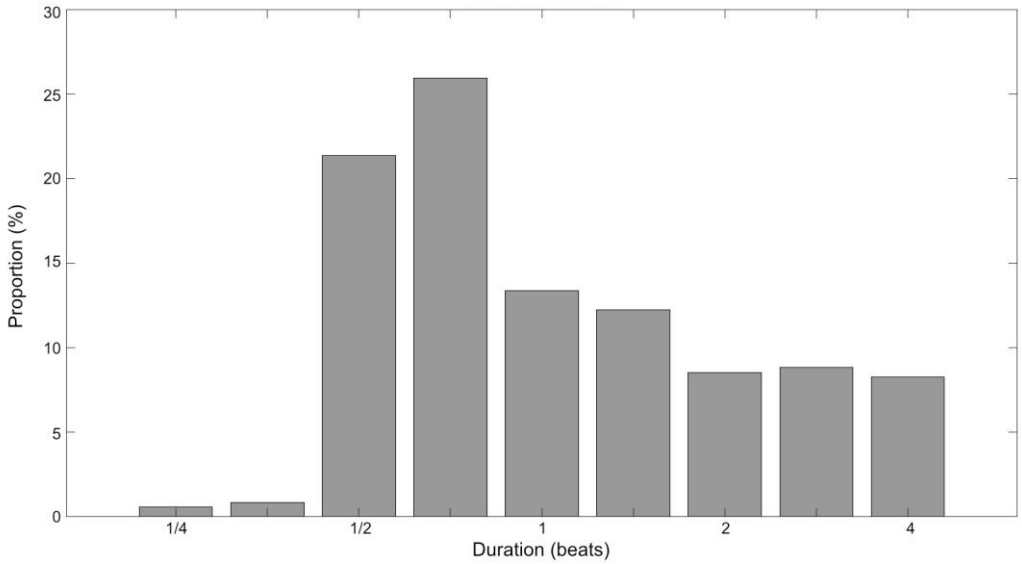


Figure 15: Distribution of note durations in improvisation #7

In Figure 15 one can see that Sara was predominantly playing notes that are between the length of an eighth note and a quarter note, which suggests that she was playing more complex rhythms than simply the basic beat (and while the fourth column does not represent dotted eighth notes as one might expect due to the use of a logarithmic scale, it represents notes that are between the length of an eighth note and a quarter note). This suggests rhythmic freedom and confidence to play more than just the basic beat. And although Sara was playing with more rhythmic freedom, one can see from Figure 16 that she was still playing within a two-beat measure structure as most of her onsets occurred on the beats. In Figure 17 one can see that the strongest autocorrelation within the beat gradually shifted, suggesting that the tempo was not steady, but the pulse was still clear.

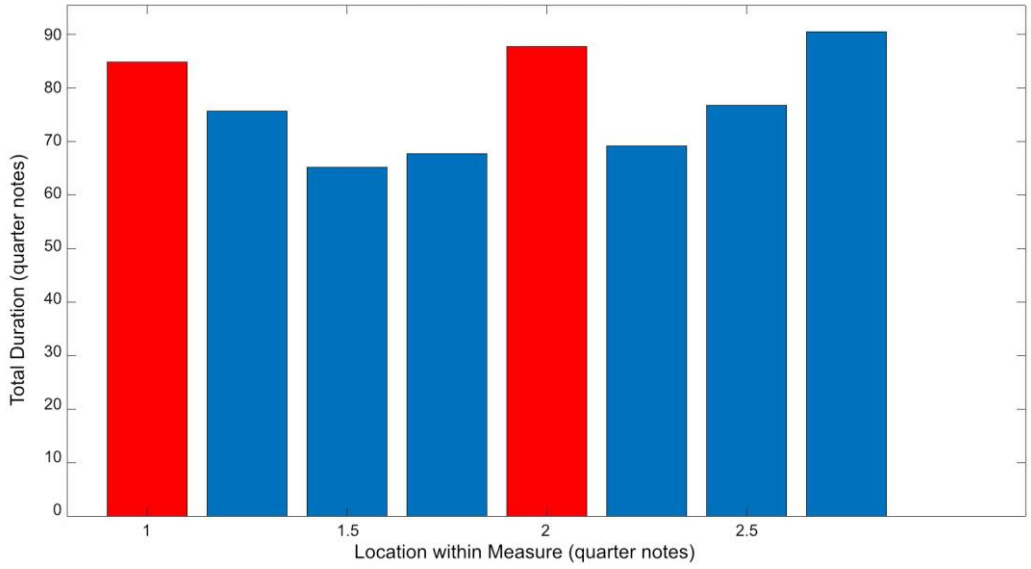


Figure 16: Distribution of note onsets in improvisation #7

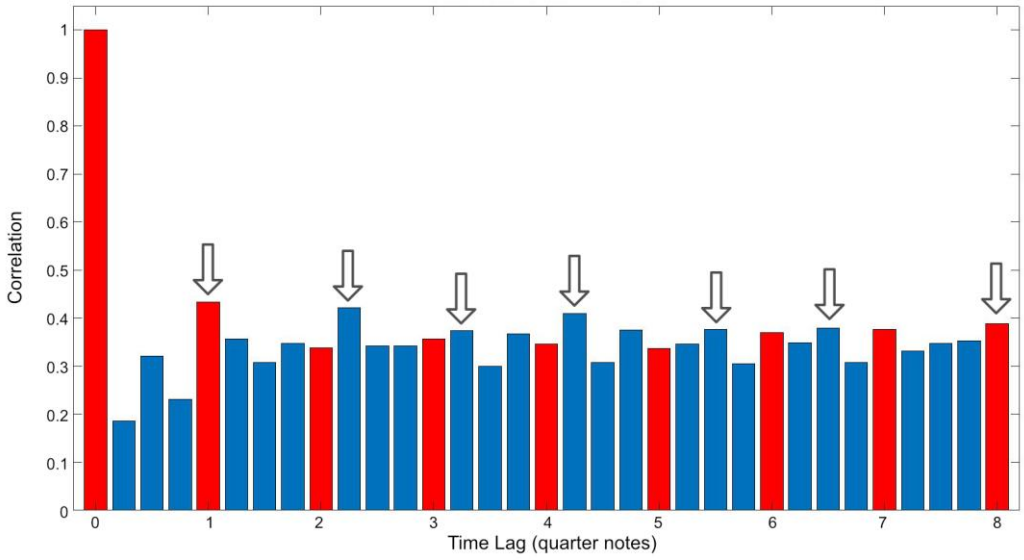


Figure 17: Autocorrelation of onset times in improvisation #7

In her imagery, Sara described a desire to move toward the fountain at the far edge of the pond which she knows will help improve her mental health. In order to do so however, Sara must allow herself to go deeper into the pond, eventually requiring her to swim. Bruscia (1987) described the meaning of rhythmic patterns, suggesting that "the patterns disturb the state of equilibrium or homeostasis, and therefore stimulate tension and the need for resolution. […] Safety is also not a matter of embeddedness, and therefore must be maintained by moving towards objects or away from objects" (p. 451). Sara now felt safe enough in the therapeutic environment to allow herself to take risks and move away from the security of a basic pulse and towards her fountain at the edge of the pond.

DISCUSSION AND INTEGRATION: REFLECTING ON THE THERAPEUTIC PROCESS

Image 5 illustrates the phenomenological themes, codes, and categories within the image of a tree that was created by the researchers to illustrate the different characteristics of Sara's therapeutic process and the qualitative data-analysis results from transcripts of sessions, the final interview, and the therapist's session notes. For Sara's therapeutic growth of self-efficacy to occur within a therapeutic environment, three factors needed to be present: flexibility, safety, and a therapeutic relationship. Within the nutritious soil, not yet visible to her outside world, grow the roots or the interventions, both verbal and musical. From these roots begins to grow the tree itself, observable by all outside of the therapy environment. The trunk of the tree represents the key factors of Sara's music therapy experience which contributed to a development of self-efficacy. These are noted within each of the five main branches. They are: self-awareness and self-care, being confident and ready, growth and expansion, coping skills, and mastery and joy. In the space surrounding the tree, one can see the subcategories within each of the five key factors of Sara's experience. These subcategories represent smaller groups of codes that were extracted from the data and provide detail and context for the main branches of the tree. In this chapter, the descriptive phenomenological characteristics of Sara's therapeutic process will be reflected and integrated with the musical microanalysis.

The soil – The therapeutic environment

Sara identified the following elements of the therapy process which influenced her self-efficacy and allowed it to grow: the therapeutic environment, specific interventions, and music. During the therapy process, Sara often discussed her appreciation for the flexibility of the sessions. Each day the activities occurring within the therapy session were adjusted based on her current state. Sara's moment-to-moment needs were addressed by working together to create each therapy session in the way most suited to her current state. A non-directive attitude was thereby achieved, and the roots of Sara's self-efficacy were able to grow.

Another nutrient within the soil of the therapeutic environment was a feeling of safety. Sara felt that the music therapy space was a safe environment which was important to her because, as she said, "I always like to try new things in a safe environment before I try them in a bigger maybe a little

bit of a scary environment". It is important for an individual to feel safe before they can begin to develop their self-esteem or self-efficacy, thereby suggesting that bringing safety to every session is a vital part of the therapist's role. Having a safe place in which to learn, explore, make mistakes, and develop coping skills allowed Sara to satisfy the human need for safety and go on to address her need for self-esteem and self-efficacy.

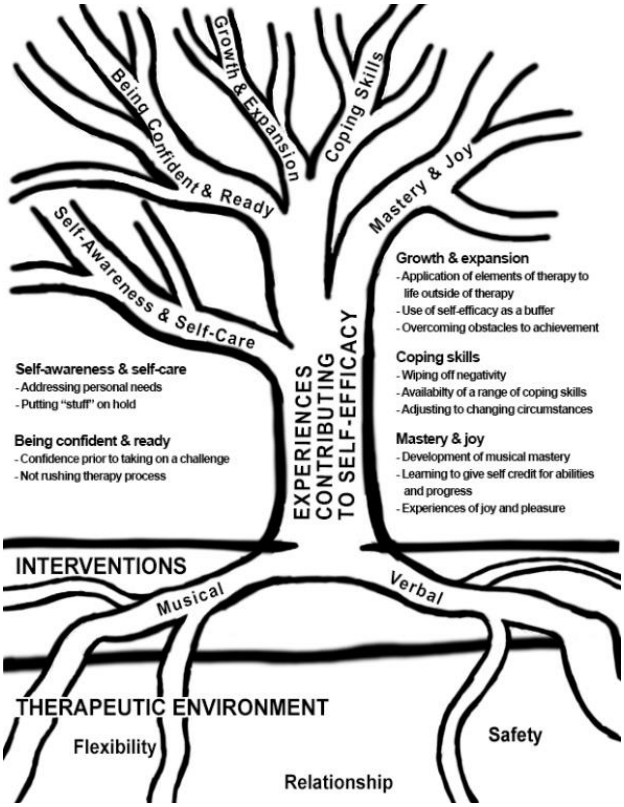


Image 5: Representation of themes and categories

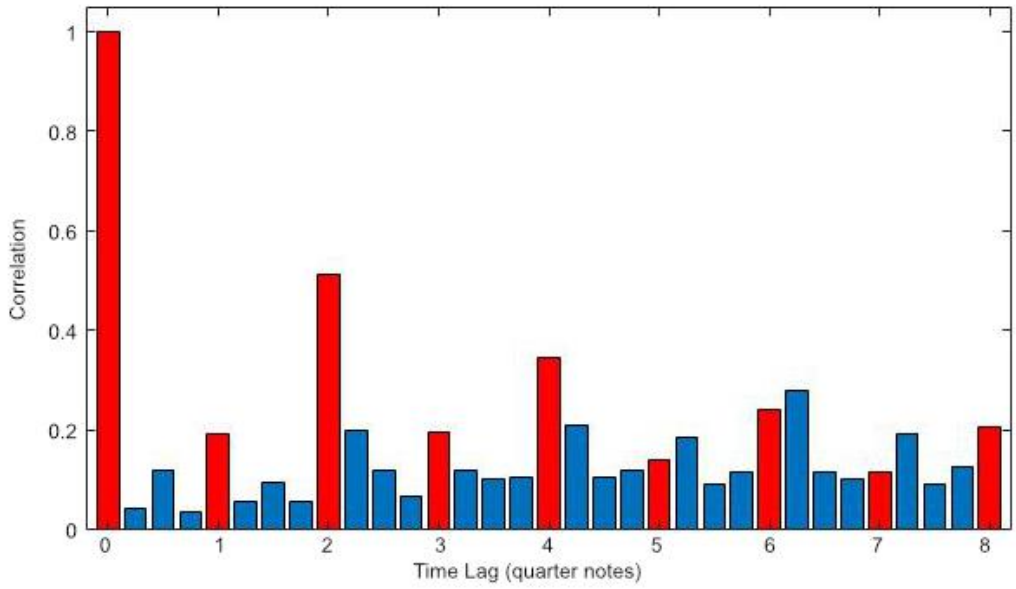


Figure 18: Autocorrelation function of Laura's onset times in improvisation #5

A therapeutic relationship is one of unconditional positive regard in which the client feels validated by and important to the therapist. It is clear from Sara's descriptions of the therapeutic relationship that it enhanced the therapeutic environment and allowed self-efficacy to grow. Sara stated in the interview "I always value having someone that's outside of your friends' circle, your family circle". One can see in Figure 18 that Laura holds a steady 2/4 rhythm throughout improvisation #5 ("Life Adventures in a Storm"). In this case Laura's steady meter provided grounding and holding for Sara during the improvisation in which she felt isolated while dealing with a storm. Bruscia (1987) suggested that "when the rhythms fit into the measure, the meter provides reassurance that the energy states, drives, and impulses are occurring in the right place at the right time, and their significance is contained within an overall value system" (p. 452). The therapist's music held a relationship with Sara's by creating this metrical structure and providing reassurance that Sara was successfully coping with the anxiety caused by the storm.

The roots – The interventions

The next category that was considered relevant was Sara's descriptions of interventions that were used within the music psychotherapy process. Sara discussed the relationship between, and relative importance of, music and words in music psychotherapy. Although Sara felt that music psychotherapy "helps you in a different way than just talking to somebody", she also appreciated the sessions in which no music was made and the time was spent in conversation. By analysing Sara's description of an ideal balance between words and music, it was noted that she felt the most benefit when the two modalities were used to compliment and feed off each other. Sara described two particular styles of intervention which contributed in equal parts to the development of her self-efficacy. The first is "you do the therapy by using music", which implies that the music itself is the agent of change. The second is "doing the therapy and trying to find it musically", which implies a method involving verbal interventions followed by music to enforce concepts discussed.

The trunk and branches – The experiences contributing to self-efficacy

The tree itself represents the experiences that Sara had through music psychotherapy, which contributed to the growth of her self-efficacy. Five branches sprout from the trunk of the tree, each of them representing one of the five key experiences: self-awareness and self-care, being confident and ready, growth and expansion, coping skills, and mastery and joy.

The first branch of the tree of Sara's growing self-efficacy is *self-awareness and self-care*. These were important experiences in Sara's music psychotherapy journey. When she first started music psychotherapy, Sara had realised that "I can't just keep doing what I'm doing, because if I keep doing what I'm doing I'm not going to succeed in the way that I need to". She had begun to realise that she was not addressing her own needs enough and that this was influencing her ability to achieve her personal goals. Sara also demonstrated significant self-awareness while listening to improvisation #5 when she described the importance of understanding physiological symptoms and how they can affect her self-efficacy. These realisations were significant to Sara's growth because it emphasises that she was aware of her own needs and acknowledged that it was important to address them. In the

final interview, Sara stated "I'm choosing to work on myself finally and do the whole soul searching and figure out what's best for me". For Sara, working on herself included the goals that were addressed in music psychotherapy: improving self-efficacy and developing confidence in new situations, such as can be seen in improvisation #1. Part of this process included learning to prioritise what was most important to her mental health. Many times throughout sessions and the interview, Sara discussed the idea that she was putting "stuff" on hold to work on herself and that she had put her own "stuff" on hold for too long. By prioritising her mental health over things such as employment, Sara was boosting her belief in her own capabilities.

The next branch of the tree is *being confident and ready* before making any change or progress. It was important for Sara to experience feelings of confidence in her ability to succeed before she would take something on. She says that "if you're not ready and you're being forced to do something, you're going to react totally different than if you're confident and ready". There were times in her life that Sara felt forced, either by internal or external sources, to do something that she was not confident and ready for, such as finding a job. Sara came to realise that she had not been fully prepared for the job she held and that it was negatively affecting her mental health. She said, "I'm just not confident enough that if those unexpected things happen that I can pull through it". Until she had built up the self-efficacy to be able to handle any such events, she would not pursue a job. This need for confidence prior to taking on a challenge can also be seen in Image 1 when Sara described the significance of each of the colours. The green jagged line represents a moment in which Sara was feeling challenged as she has pushed herself outside of her comfort zone. However Sara needed time to prepare for those moments by breathing deeply and taking caution, represented by the red and yellow lines.

Another important branch of Sara's self-efficacy is her *growth and expansion*. This category includes all of Sara's experiences of applying elements of the therapy sessions to her life outside of the therapy, her use of self-efficacy as a buffer for when traumatic events happen, and overcoming obstacles to achievement. Sara shared that there were moments of learning and experimentation that she explored in the music psychotherapy space that felt good to her in a safe environment but would take further development of self-efficacy to explore in another environment. In the final interview she stated*: "My home would be my next safe place, and then certain great friends' places would be my next safe place, and then eventually it would just trickle out, and then eventually I'm in the middle of the city and then randomly I would feel comfortable doing stuff."*

A significant example of this is represented in Sara's quotation regarding communication in Image 1. She suggested that she used music psychotherapy as a safe environment in which to practice communication skills before putting them to the test outside of music psychotherapy. Gallagher (2012) suggested that individuals are more likely to approach perceived threats if they believe they are able to handle the situation, in other words, if they have a higher level of self-efficacy. In Sara's case, stepping outside of her comfort zone was less difficult to achieve within the therapy situation, and became more difficult as she went into each of the earlier mentioned locations. However, as her level of self-efficacy increased, Sara was able to expand her improved communication skills into other areas of her life.

Sara also felt that achieving her goals and developing her self-efficacy would be beneficial in situations in which her confidence and self-esteem are tested. Sara shared that she had experienced

traumatic events in the past and these events caused her confidence and self-esteem to "go backwards". She said, *"right now if it hits me, I'm getting pushed back and there's no resistance to it"*. By achieving her goal of developing her self-confidence and self-esteem, Sara understood that *"even if I get pushed back it won't affect me that much and I can still move forward"*. In image 3, Sara described how she dealt with both the loss of her grandmother, and the anniversary of the loss. These were both very difficult situations for her and yet the development of her self-efficacy allowed her to avoid being "pushed back" too far when the anniversary arrived.

Associated with growth and expansion is also the experience of overcoming obstacles and coping with what Sara considered to be mistakes. One obstacle to Sara's growth of self-efficacy was her fear of failure. Music was an ideal way to assist Sara in overcoming this obstacle to her growth. For example, during a particular improvisation, Sara felt that she played some wrong notes. In the discussion following this improvisation, Sara was pleased to realise that she had been able to continue playing after these accidental extra notes. Sara shared how this situation can be related to non-musical life events and how her reaction to mistakes had changed since she started music psychotherapy. The following is Sara's description of that improvisation in session 3.

> I usually get frazzled and then my walls come up. I'm like 'oh, I don't want to do this, it's too overwhelming, I don't know how to push through it'. And then I shut down and then I'm like 'OK now I have to go back to it a little bit later to figure out the solution'. Well, this time I just went on head-on without any breaks and kept on going and it turned out well. So that was actually pretty cool. I did a couple other notes than the stickers that we have on this thing but it's kind of like it did it on purpose because it could show me that 'you know what? You did do that, but you also didn't stop. Because you could have stopped the recording and said OK, well, whatever, we'll start again'. But no, I kept on moving. Ya, that is kind of like life too because you have a little glitch or a pause or a situation, like a death, like my Granny I guess, and how you push through. Before we started working together, I probably would have handled that death situation totally differently.

Nachmanovitch (1990) wrote a book chapter on the power of mistakes. He wrote that "the quirks and mishaps that one might be tempted to reject as 'bad data' are often the best" (p. 91). It was because of this musical "mistake" that Sara came to realise that she had grown to be able to cope in a more positive way with unforeseen situations.

Throughout the therapeutic process, Sara also discussed the development and use of various *coping skills.* Not only did she feel that music psychotherapy was valuable for the development of her coping skills, Sara appreciated that she was learning to combine various techniques, to choose the best coping skill for the situation, and to adapt to changing situations. One of the coping skills that Sara discussed most during her time spent with music psychotherapy was the ability to "wipe off" negativity. Sara spoke of a situation in which she asked for a friend's opinion of something and she was prepared for any response.

> Maybe what they're saying is true, maybe it's not, or maybe they're just giving you an idea to think about. But ultimately, you know you best. So if you think it's true, well then it's true because that means you're agreeing with it. If you don't and you think it could be true, then what are some steps that you could do to make it true? And if it's totally not a true statement, then it's kind of cool that you can learn to just wipe it off. And then as you're learning the different skills, it will determine if you can wipe things off faster and if it will bother you for less time than other things.

Sara demonstrated not only an awareness of the coping strategies she held, but also an awareness of how to effectively use those skills in the moment. She said, "it's just trying to figure out in those frustrating times when one coping skill doesn't work, how quickly can you add in one of your other ones to fix it?". This heightened level of self-awareness regarding coping strategies suggests also an increased belief in her own ability to implement an appropriate strategy when facing a difficult situation.

The final branch of Sara's tree of self-efficacy is experiences of *mastery and joy*. "Mastery experiences are the most effective method of developing self-efficacy beliefs" (Gallagher, 2012, p. 315) and therefore Sara's feelings of pride in her musical mastery were important indications of the development of her self-efficacy. In the interview, Sara stated "I knew a little bit of music stuff when I started but can you imagine now what I have? I might not be playing [the instruments] the right way, but I certainly know a lot more". On the drum, which was not used in the data collection sessions due to the inability to collect MIDI data, Sara went from simple exploration of sounds with no rhythmic stability to complex and creative rhythmic drumming over the course of the music psychotherapy process. On the xylophone or mallet instruments, she began the process with little willingness to explore the instrument and by the end of the sessions had a capacity to play melodically and rhythmically, using the entirety of the instrument's range. At the outset of music psychotherapy Sara did not use the keyboard or piano, however eventually she began using the instrument with stickers to dictate which notes she would use in each improvisation, thereby keeping it accessible and non-threatening

In the concluding interview, Sara and the researcher listened to two recordings of musical improvisations conducted on the MIDI instruments. The first recording they listened to was the very first one created in the research lab, and the second was the very last (which was not microanalysed in this study). Sara was then asked to describe what she noticed that was different between the two. Sara's response was as follows:

> I found that the second one was a little more put together than the first one. I think we were more together in what we were making than the first one, where it was a little more choppy. The first time I was more on one sound only, which is loud, which is kind of funny for me because I don't like being loud at all, but I guess with that I did. And then this one, it's that confidence thing right? I was way more confident, and I was able to put more into it. Whether it was more levels of loudness, like there was some quiet in there, some medium sound, and it's not

> just one tone, there's more levels to it which is pretty cool. I just thought the second one was a little more put together, like what an actual instrumental piece could have been like.

In this statement, Sara indicated that not only did the experiences of mastery contribute to her self-efficacy, but confidence contributes to what she considers to be more aesthetic musical performances. In this way, musical mastery and self-efficacy can be seen to develop simultaneously in a positive cyclic manner, continually contributing to the growth of the other.

Through music psychotherapy, Sara came to realise that there are times that she does not "give herself enough credit" for her abilities and for her progress. In the third session she said

> I actually am improving, more than I actually think sometimes. That's not a bad thing. That really is not a bad thing. So me thinking I'm taking little steps, but maybe I'm actually more on a medium or larger step and I'm just not really picking up on it. But maybe that is actually happening and it's not so much the small steps all the time; maybe I am doing those other ones too.

Sara broke away from a tendency to doubt her own progress when she realised the extent to which her musical mastery had developed. She acknowledged that "maybe in some areas that I think are lacking, maybe I'm just not giving myself enough credit". This statement indicated an improvement in self-efficacy as Sara realised that she had more internal resources and mastery than she was originally accounting for.

Another important element of the therapy process and contributor to self-efficacy are experiences of joy and pleasure. Sara clearly enjoyed making music and listening to the recordings of her own improvisations, stating "wow! I could dance to some of those!" after listening to a recording from the first session and a recording from the last session. Sara's choice of image 4 is also a significant example of her experiences of pleasure during music therapy. She described this image as her happy place, a place where she feels calm and relaxed. Gallagher (2012) wrote about the manner in which emotional cues can contribute to the development of self-efficacy, suggesting that "the extent to which individuals are emotionally/physiologically aroused can have minor effects on the level and strength of self-efficacy beliefs" (p. 316). Therefore, when Sara was in a positive and joyful state, it can be understood that this would have a positive impact on her self-efficacy.

CONCLUSION

The aim of this research study was to develop an understanding of how improvisational music psychotherapy influenced Sara's self-efficacy and how musical analysis of the improvisations could shed light on Sara's therapeutic process. The research questions were (1) What is Sara's perspective on meaningful moments that influenced her self-efficacy during music therapy improvisations? (2) What are the important features of improvisational music psychotherapy that contribute to the development of Sara's self-efficacy? (3) How can music psychotherapy influence the self-efficacy of a client with anxiety and depression? (4) How can musical microanalysis enhance the understanding of therapeutic processes and change?

Throughout the music psychotherapy sessions and the interview following her therapeutic process, Sara discussed several moments which influenced her self-efficacy. The main themes that Sara discussed regarding this topic were addressed in the discussion and integration section and were represented by the image of a tree. The five core experiences within music psychotherapy that contributed to Sara's self-efficacy were self-awareness and self-care, being confident and ready, coping skills, growth and expansion, and mastery and joy.

The most important features of improvisational music psychotherapy that contributed to the aforementioned experiences included the therapeutic environment and musical and verbal interventions. With the occurrence of flexibility, safety, and a positive relationship within the therapeutic environment, Sara was able to use the interventions in the way most suited to her needs.

The use of microanalysis tools allowed for an understanding of how Sara's meaningful moments and self-efficacy were represented in the music. Microanalysis of Sara's improvisation showed musical features which were interpreted as accurate representations of her imagery and interpretation of the music. However, some limitations do arise from this process as well. For example, any meaningful moments that occurred during improvisation with acoustic instruments could not be analysed in this way; and certain metrical analysis features may provide slightly skewed results due to an inability to detect tempo changes.

When considering the impact that these music psychotherapy sessions had on Sara, it should be taken into consideration that six sessions were conducted using MalletKats and MIDI keyboards. These instruments may not be readily accessible to most music therapists; however they could also contribute to therapeutic growth for clients. By using the MIDI music therapy toolbox to analyse the musical data in the MATLAB software and allowing the client to view the results, it can offer the client opportunities for self-confidence, pride, and empowerment. The software can also allow a considerable amount of data to be shown during the therapy session whereas a microanalysis by hand would take a long time before it could be accessible to the client. With the software, the client can see concrete data about the music they created and feel pride in how it looks and how it sounds. They may be able to notice differences in the analysis of their music as they progress in their therapy.

With a new understanding of a client's self-efficacy within music psychotherapy, one might be interested in future studies which consider how musical microanalysis might represent other elements of a client's therapeutic goals. It could also be interesting to explore how musical microanalysis could be used within the therapeutic process with the client during the process to assist with therapeutic change, as opposed to being used on completion of the therapeutic process to understand the changes that occurred for the client. It could also be interesting to use microanalysis as a clinical tool by the therapist themselves to inform how they interact in the session.

It is important to note that the results of this study may be influenced by the primary author's stance as both therapist and researcher. This could lead to confirmation bias in which the researcher interprets data in a way that confirms the hypothesis. In this study we tried our best to avoid this through peer review and regular clinical and research supervisions. Sara's perspective on this strengthened the validity of the research findings.

ACKNOWLEDGMENTS

We would like to thank Linda Gambell, RP, MTA, for working as a clinical supervisor during the therapy sessions. We would also like to thank the Manfred and Penny Conrad Institute for Music Therapy Research for their support. Many thanks also to Liisa Steinwedel for making Sara's description of her imagery come to life in Image 4.

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Ελληνική περίληψη | Greek abstract

Αξιοποιώντας τη μουσική μικροανάλυση και την φαινομενολογία για την βαθύτερη κατανόηση του αντίκτυπου της αυτοσχεδιαζόμενης μουσικής ψυχοθεραπείας στο αίσθημα αυτοαποτελεσματικότητας ασθενούς με κατάθλιψη και άγχος

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ΠΕΡΙΛΗΨΗ

Σκοπός της παρούσας έρευνας μεικτής μεθοδολογίας ήταν να μελετηθεί το πώς η αυτοσχεδιαζόμενη μουσική ψυχοθεραπεία που διεξάγεται μέσω της χρήσης ψηφιακής διεπαφής μουσικών οργάνων (MIDI) έχει αντίκτυπο στο αίσθημα αυτο-αποτελεσματικότητας ενός πελάτη, όπως αυτό ορίζεται σύμφωνα με την αντίληψή του πελάτη ως προς την ικανότητά του να επιτυγχάνει στόχους. Συγκεντρώθηκαν δεδομένα από τις μεταγραφές των συνεδριών, από αρκετές συνεντεύξεις με την πελάτισσα (Σάρα) καθώς και από μουσικές πληροφορίες. Στη μουσική μικροανάλυση έγινε χρήση των δεδομένων από τη μουσικοθεραπεία, τα MIDI και τα MIR εργαλεία εντός του MATLAB. Η συνεργατική ανάλυση των δεδομένων συμπεριέλαβε και την προοπτική της πελάτισσας. Τα αποτελέσματα έδειξαν ότι η το αίσθημα αυτο-αποτελεσματικότητας της πελάτισσας επηρεάστηκε από ποικίλες μουσικοθεραπευτικές εμπειρίες συμπεριλαμβανομένων των εμπειριών αυτεπίγνωσης και αυτο-φροντίδας, της αυτοπεποίθησης και της ετοιμότητας για αλλαγή, της ανάπτυξης και εξέλιξης εκτός θεραπευτικού πλαισίου, της ανάπτυξης των δεξιοτήτων αντιμετώπισης προβλημάτων και της αυτοκυριαρχίας και της χαράς. Μέσα από τη μουσική μικροανάλυση, φάνηκε ότι συγκεκριμένα μουσικά χαρακτηριστικά ήταν άμεσα συνδεδεμένα με τη φαντασία της πελάτισσας, τη διάθεσή της και τις εμπειρίες αυτο-αποτελεσματικότητάς της. Η έρευνα προσφέρει ένα παράδειγμα του πώς μπορεί να αξιοποιείται η μουσική μικροανάλυση για τη βαθύτερη κατανόηση της θεραπευτικής αλλαγής και των θεραπευτικών διαδικασιών.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

κατάθλιψη, άγχος, ψυχική υγεία, αυτο-αποτελεσματικότητα, μουσική ψυχοθεραπεία

Approaches: An Interdisciplinary Journal of Music Therapy
15 (1) 2023

ISSN: 2459-3338 | www.approaches.gr

ARTICLE

The impact of group music therapy for individuals with eating disorders

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ABSTRACT

This mixed-methods study examined the impact of group music therapy upon individuals receiving inpatient treatment for eating disorders. There was a total of 21 participants ranging between the ages of 16 and 58. Participants' lived experiences of music therapy, including music's effects on mood and emotion regulation, were explored. Data collected through the "PANAS" (Positive and Negative Affect Scale) (Watson et al., 1988), and subscales of the "DERS" (Difficulties in Emotion Regulation Scale) (Gratz & Roemer, 2004), and "ERQ" (Emotion Regulation Questionnaire) (Gross & John, 2003), demonstrated that participants experienced a decrease in negative affect, as well as an increased ability to express emotion after participating in music therapy. Data collected through audio recordings and transcriptions of music therapy and focus group sessions suggested that, through creating and playing music together, participants discovered music's ability to represent various aspects of themselves and their recovery journeys, music's potential to support them to externalise, shift, and stay with emotions, and music's capacity to foster social connection.

KEYWORDS

music therapy,
eating disorder,
improvisation,
emotion regulation,
mixed methods

Publication history:
Submitted 26 Oct 2020
Accepted 27 Mar 2021
First published 18 Jul 2021

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INTRODUCTION

Approximately one million Canadians are diagnosed with an eating disorder (NIED, 2020a). Incidence rates globally are mainly based on registered inpatient and outpatient cases and as many eating disorders go unreported, it is hard to obtain accurate global data (Hoek, 2016). According to Erskine et al. (2016), anorexia nervosa and bulimia nervosa ranked twelfth in the leading cause of disability-adjusted life years in females aged 15-19 years in high-income countries in the 2013 Global Burden of Disease Study (GBD). The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) presents diagnostic criteria for six feeding and eating disorders, including pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, and binge-eating disorder (American Psychiatric Association, 2013). Treatment for these disorders often includes nutritional restoration and maintenance, behavioural therapies, and psychotherapy (Treasure, 2016). Creative arts therapies, including music, dance, drama, and art therapy, are also used frequently, supported by research that affirms their "non-threatening" nature, as well as their ability to help clients "identify feelings and integrate new insights into utilizing positive ways of coping" (Heiderscheit, 2016, p. 20). Music therapy for individuals with eating disorders aims to facilitate the identification, regulation, and expression of emotions, and offer support through the development of musical and therapeutic relationships (Bauer, 2010; Bibb et al., 2015; Bobilin, 2008; Heiderscheit, 2008; Hilliard, 2001; Justice, 1994; Lejonclou & Trondalen, 2009; McFerran, 2005; Nolan, 1989; Pasiali et al., 2020; Pavlakou, 2009; Shuman et al., 2016; Trondalen, 2003, 2016a, 2016b; Trondalen & Skårderud, 2007).

This study explores the use of group music therapy, largely improvisation-based, within an inpatient eating disorders treatment setting.

LITERATURE REVIEW

Eating disorders develop due to a combination of biological, psychological, and socio-cultural factors (NIED, 2020b; Palmer, 2015; Treasure, 2016). People of all ages, genders, and backgrounds can develop and be affected by eating disorders (NIED, 2020a) and comorbidity with other psychiatric illnesses is common for individuals with eating disorders (Gadalla & Piran, 2009; Meng & D'Arcy, 2015; Perez et al., 2004; Piran & Gandalla, 2006; Reel, 2018; Treasure, 2016).

Eating disorders are severe mental illnesses that are characterised by controlling thought patterns and behaviours and often involve rigid rules about food (Antony & Swinson, 2009). These behaviours both contribute to and are fuelled by low self-esteem and self-worth (Trondalen, 2016a), and as the illness worsens, the eating disorder in fact "controls the person" (Loth, 2016, p. 301). Personality traits such as perfectionism and cognitive rigidity also increase the risk of developing an eating disorder (Treasure, 2016). Though eating disorders are separated according to symptomatology in the DSM-5, it is important to note that there is significant overlap between each diagnostic category and associated behaviours. We recognise that each individual has their own complex and fluid etiology and symptomatology (Treasure et al., 2010).

People with eating disorders often have difficulties in regulating emotions, demonstrating either high levels of emotional control, that is, "[inhibition of] their response to an emotional state," or in contrast, impulsivity, "engag[ing] in a behaviour prematurely" (Van Blyderveen et al., 2016, p. 77). Emotion regulation refers to the control that "individuals exert … over their emotions, using a wide range of strategies to influence which emotions they have and when they have them" (Gross & John, 2003, p. 348). The association between emotion regulation and eating behaviours is well-documented (Corstorphine et al., 2007; Engel et al., 2005; St-Hilaire et al., 2017; Tchanturia et al., 2004; Van Blyderveen et al., 2016). Emotion regulation and responses to food are connected; Van Blyderveen and her colleagues noted that individuals high in emotional suppression are at risk for dietary restriction whereas individuals high in impulsivity are at risk of increased caloric intake. Individuals with bulimia nervosa (BN), or the bingeing/purging subtype of anorexia nervosa (AN), tend to have higher levels of impulsivity than individuals with AN restricting subtype (Engel et al., 2005), and individuals with AN have higher levels of cognitive rigidity than individuals with BN (Tchanturia et al., 2004).

The research cited above influenced our decision to examine music therapy's impact on emotion regulation. We recognised that our clients demonstrated behaviours along the spectrum of impulsivity to restriction, and that music, particularly musical improvisation, can provide experiences anywhere along the related continuum of structure to freedom. A growing body of research suggests that music therapy has important clinical implications for individuals with eating disorders. Trondalen (2016b) proposes that music therapy is "a *life giving* condition" (p. 32, emphasis in original) in opposition to the eating disorder itself. Musical improvisation offers a unique opportunity to clients with eating disorders to recognise and connect with their emotions, providing "a physical manifestation of one's emotions and thoughts as they flow through time" (Bobilin, 2008, p. 145). Music's ability to elicit emotions—present in any context—is significant here given that many people with eating disorders display alexithymia, described as an inability to identify/describe emotions and differentiate between feelings and body sensations (Nowakowski et al., 2013; Trondalen & Skårderud, 2007). Improvisation allows individuals to "acknowledge their presence physically by playing an instrument" (Trondalen, 2016a, p. 109), using their bodies in meaningful and non-harmful ways whilst expressing themselves and interacting with others.

Musical improvisation can also address emotional control, rigidity, and impulsivity, as it requires flexibility and control (Heiderscheit, 2008; Lee, 2015). For example, a client's issues of emotional control may be exhibited within a musical improvisation through rigid playing or imitation of the therapist (Pasiali et. al., 2020). Heiderscheit (2008) comments that "the flexibility of music as a therapeutic agent allows the therapist to individualize the process and also meet a wide variety of needs simultaneously" especially when "feelings and emotions may be fragmented, elusive, and inaccessible to language" (p.128). Research examining the neuroscience of creativity highlights the relationship between engagement in musical improvisation and the "arousal of subcortical areas and neural networks that stimulate action and inhibit self-monitoring" (Tomaino, 2013, p. 85). This has significance for individuals with eating disorders and their accompanying psychological self-monitoring tendencies including "perfectionism, a sense of inadequacy, low self-esteem, hypersensitivity to criticism, and difficulty identifying and expressing emotions" (Reel, 2018, p. 34), all of which can render improvisation particularly challenging and also clinically relevant. In her study examining group singing for people with eating disorders, Pavlakou (2009) recommended facilitating

group singing as a structured musical experience while building rapport, given her participants' struggles with issues of control. Similarly, Bibb and McFerran (2018) examined the role of group singing in mental health recovery and found that group singing was helpful in providing participants with both intra- and interpersonal resources and promoting healthy relationships with music. Recognising the challenges associated with improvisation for clients with eating disorders, we intentionally included some structured musical experiences within sessions, including group singing, while we also pointedly examined the potential benefits of improvisation, grounded in the research cited above.

METHODOLOGY

This study's design allowed for participants[1] to guide the direction of the research as much as possible. Specifically, we wanted to discover:

1. What are the lived experiences of participants with eating disorders in group music therapy?
2. In what ways, if any, do participants' moods and emotion regulation behaviours change during participation in music therapy?

We combined a phenomenological approach with a concurrent triangulation mixed methods design (Creswell, 2007). Our study implemented a convergent parallel single-study design (Bradt et al., 2013) in which both quantitative and qualitative data were collected concurrently with equal emphasis, then integrated after separate analysis, allowing us to examine their points of intersection and distinctions. Phenomenological research, which embodies an interpretivist epistemology, seeks to understand "the meanings that emerge as individuals experience phenomena in their everyday lives" (Hiller, 2016, p. 109). Our non-positivist and constructivist perspective on research aligns with the humanistic, resource-oriented, and music-centred approach to music therapy used within these sessions (Aigen, 2014; Rogers, 1961; Rolvsjord, 2010).

Research setting

This study was approved by the Research Ethics Boards both at Wilfrid Laurier University and the facility at which this study was conducted. This research was conducted at a mental health and addictions facility in Southwestern Ontario, Canada. Patients within the 21-bed eating disorders program receive largely group-based treatment from an interdisciplinary team, with psychoeducation and psychotherapy sessions based upon dialectical behaviour and cognitive behavioural therapy models. In addition, patients participate in creative arts programming along with recreation, horticultural, and music therapies. All of these therapies are undertaken in group settings, allowing more patients to access services and aligning with the facility's overall treatment philosophy.

[1] We will be using the terms "patients" and "participants" interchangeably throughout this paper. Though it is commonplace in our field to refer to those with whom we work as our "clients", the term "patients" is used most often at the facility at which this research was conducted, by both staff members and service users alike.

Music therapy group sessions are offered once per week for individuals in the eating disorders program. The sessions included in this research involved a combination of improvisation, singing, drumming, listening back to recorded group improvisations and responding through visual art, and mindfulness-based exercises.

Improvisations were either referential or non-referential. Referential improvisations typically involved expressing and shifting between different emotions or images. For example, in an improvisation based upon the image of a storm, participants were invited to use their instruments to evoke the calm before a storm, the peak or intensity of the storm, and finally, the calm after the storm. In "Emotion-Shift" improvisations, participants chose a challenging emotion to begin with and a desired emotion to gradually transition to, through the improvised music. In an improvisation titled "I Was, I Am, I Will Be" (Payne, 1995), group members began by brainstorming words to complete each of the title phrases, based upon their own experiences. These words were written down on the whiteboard by the facilitators, and then the group was asked to improvise through each section, using the words as inspiration. The facilitators supported these improvisations by accompanying either on the piano or percussion. In group drumming, patients were taught simple and repetitive rhythms to play together, and then encouraged to explore on their own, creating their own patterns as they felt comfortable within the overall structure of a consistent steady beat. In group singing, patients often selected a meaningful song for the group to sing together.

Music therapy sessions were co-facilitated by four Master of Music Therapy students; two students—including this paper's first author, now the facility's music therapist—co-led the first two research groups, and two additional students co-led the third research group. The facility's music therapist at the time of the research—this paper's second author— observed all sessions and provided individual clinical supervision to all students.

Research participants

All patients in the eating disorders program were welcome to attend group music therapy, regardless of whether they wished to participate in this study. The facility's music therapist shared information about the four-week music therapy group to all eating disorder patients during a regularly scheduled weekly meeting. The music therapist explained that participation in the music therapy group was optional, and in addition, that patients could participate in music therapy without participating in the research component. Patients then informed staff members on the unit if they were interested in attending.

There were 21 participants in total, ranging in age from 16 to 58: 20 identified as women, and one identified as a man. Five patients were diagnosed with BN and 16 with AN; of those patients diagnosed with AN, 12 were diagnosed with bingeing/purging subtype and 4 with restricting subtype. The majority of participants were also diagnosed with comorbid psychiatric disorders, including major depressive, bipolar, post-traumatic stress, generalised anxiety, and substance-use disorders. Research participants were split into three separate groups. Each research group was composed of individuals at different stages of treatment and recovery, and with varying familiarity with music therapy. These distinctions undoubtedly led to differences between the groups, though as evidenced by the results, certain experiences were found to be prevalent across the three research groups.

Data collection and analysis

Qualitative data consisted of transcripts of participants' verbal and musical contributions from music therapy and focus group sessions. In total, twelve music therapy sessions—four with each research group—and three focus groups were audio recorded and transcribed for analysis. During focus groups, research participants were asked a series of questions (see Appendix) and listened back to and discussed recordings of group improvisations. Focus groups were chosen as a method of qualitative data collection as opposed to individual interviews because they were deemed to be less intimidating for participants who were primarily familiar with the facilitators in a group format. The focus groups also allowed the facilitators to continue observing group processes, understanding that participants develop their perspectives through engaging with one another (Mwangi & Bettencourt, 2017). In addition, the focus groups provided an opportunity for participants to listen back to group improvisations collectively, fostering connectedness. Focus groups were led by the facility's music therapist and one Master of Music Therapy student.

Interpretative Phenomenological Analysis (IPA) (Smith et al., 2009) was used as a framework for analysis. In IPA, "participants make sense of their experiences and the researcher, in turn, interprets the participants' meaning-making to gain a fuller understanding of the experience" (Ghetti, 2016, p. 776). Topics from transcriptions were grouped into codes using NVivo software. The codes were then grouped to represent emergent themes (Pothoulaki et al., 2012), and finally, recurrent themes relevant to all three research groups were identified.

In addition to qualitative data, three self-reported measures (PANAS, DERS and ERQ) were collected to provide progress measures of emotional state. At times, patients had to miss one of the music therapy sessions due to illness or conflicting appointments. In addition, several patients were unexpectedly discharged early from the program. Thus, though there were 21 participants in total, not every participant filled out every scale. These absences from sessions are reflected in the tables in the Results section.

The Positive and Negative Affect Scale (PANAS; Watson et al., 1988) is a 20-item self-reported measure constructed to assess positive (PA) and negative (NA) affective states. Both the PA and NA scales have high internal reliability, with the coefficient alpha ranging from .86 to .89 on PA and from .84 to .87 on NA across various time frames. In this study, participants were asked to complete the measure based on how they felt at that moment, where the internal consistencies were: PA (α= 0.89) and NA (α=0.85). Participants filled out the PANAS scale before and after each session.

The Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004), is a widely used self-reported measure of difficulties in emotion regulation. In this study, participants received only the "difficulties controlling impulses when experiencing negative emotions" subscale, which has good internal consistency (α=0.86). The Emotion Regulation Questionnaire (ERQ; Gross & John, 2003) is a 10-item self-reported scale assessing two strategies one may adopt to regulate emotion: cognitive reappraisal and expressive suppression. Ratings are made on a seven-point Likert Scale. In this study, participants received only the expressive suppression subscale, which has a good reliability (α=0.73) and test-retest reliability (α=0.69).

Participants filled out the ERQ and DERS scales before the first session and after the final session. The results of these scale measurements provided insight into how group music therapy may have impacted participants' self-reported levels of rigidity and impulsivity as well as affect and mood regulation. Data were analysed using IBM SPSS Statistics. Results were described as mean and standard deviation (SD) for emotional state (DERS and ERQ) and affective state (PA and NA). To determine differences in emotional and affective state before and after music therapy, paired t-tests were used. The P value of <0.05 was considered statistically significant.

RESULTS

Qualitative results

Three main themes emerged from the qualitative data analysis: that music may represent various aspects of the self and the recovery journey, that music can support externalising, shifting, and staying with emotions, and that music may foster social connection. These results are summarised in Figure 1 and are explored in the sections that follow.

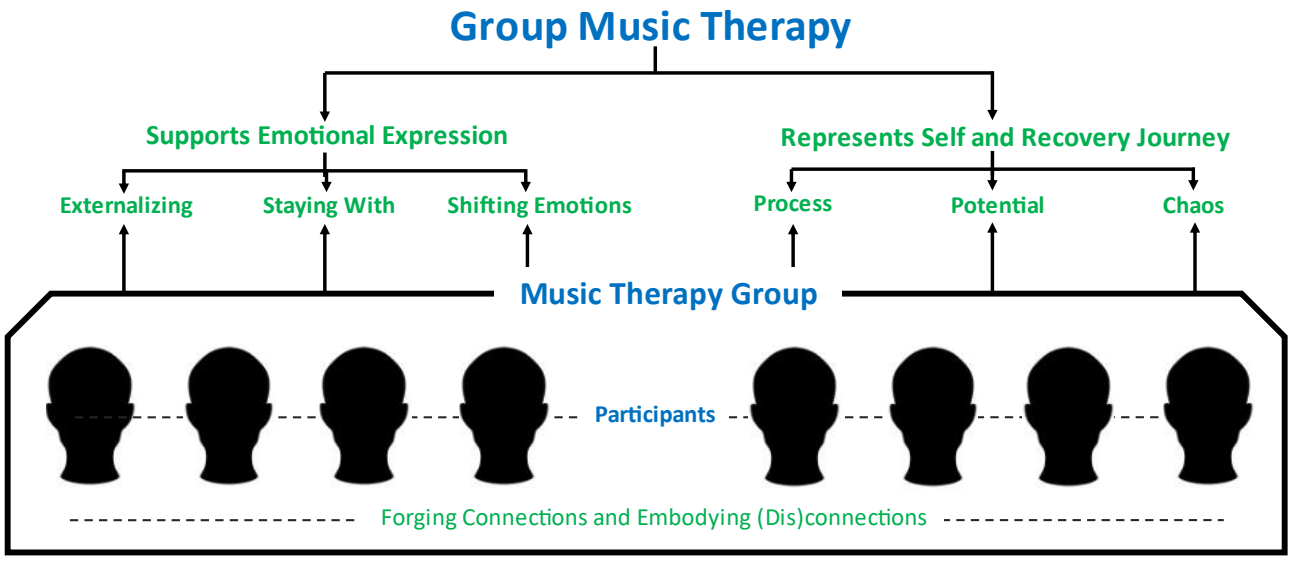

Figure 1: Qualitative results

Music and the recovery journey

Music, in particular improvised music, was seen by participants as representing aspects of themselves and their recovery journeys. We observed that the music often appeared to reflect back to participants the feelings they had about themselves—"this music sounds as my feelings feel" (Ahonen-Eerikäinen, 2007, p. 153)—while also allowing them to view themselves within the wider context of their circumstances and community. This meant that music could contain hopes and visions for potential and wholeness; at other times this meant the music sounded chaotic and stuck.

Music and chaos

Participants often struggled with the unpredictable, and at times messy, nature of group improvisation, perceiving the music to be chaotic and judging themselves for this. Participant (P) 12 recalled, "I could hear some of my instruments and they weren't on time…It felt like chaos to me." Self-criticisms were typically connected with a preoccupation surrounding getting the music "right." P20 commented on the impact of having received prior musical training on her perception of right/wrong notes:

> The first session was really challenging, 'cause I wasn't used to improvising... Whenever I've done music it's always been on [sheet] music. On the first recording I couldn't hear myself. I was specifically playing quiet so that I couldn't hear myself… As the sessions went on I got more comfortable.

P8 reflected on her fear of "play[ing] the wrong note" and shared, "The drum felt less threatening somehow, than the glockenspiel…where you could feel pressure to make a tune." Similarly, P10 shared her worry surrounding the creation of musical ideas: "If I wanted to come up with a rhythm... I had no idea what to do."

Listening back to improvisations was also often challenging, due to participants' self-critical tendencies. P7 reflected, "Listening to [the improvisation] gave me a lot of anxiety, 'cause [my] notes were *so* loud." She shared, "You could hear it boldly. I had a lot of feelings, like I shouldn't have played it." Simply the fact that one's own playing was *audible* was at times enough to prompt self-criticism. P17 remembered, "When I was playing I couldn't really hear myself, but when I heard the recording I felt like…the loudest. I felt a bit of judgement... but, I enjoyed it." Notably, many participants who initially struggled to cope within group improvisations experienced decreased self-judgement over time. P2 appreciated that music therapy provided a "break from perfectionism" and P17 observed a lessening in her own self-criticism: "I've been gaining more confidence in improvising and not being judgmental." P3 recalled, "Making noise is an issue for me… but every session was easier than the one before."

Musical experiences that contained more structure and predictability, such as group drumming, often promoted feelings of safety and comfort. For example, P7 reflected, "I liked when we were all playing the same instruments... like if we were all drumming... It felt safe." On the other hand, several participants found that over time, it became easier to stay with the discomfort inherent in improvisation; participants were able to accept the music's unpredictability and connect the musical process with their unpredictable processes of recovery.

Music, process and potential

Many participants *heard* their own recovery journeys and potential reflected back to them in the music they made and recorded. For example, in listening to one improvisation, P20 initially judged her own playing, but then noted: "It was like chaos at the beginning…In the middle it got a little bit stronger, and then at the end it came together... It just was indicative of the journey that we're all on right now." P16 echoed, "It *was* chaos," at that moment speaking about her past experiences with her eating disorder as reflected in the music. We observed many participants speaking metaphorically in this

way, allowing them to make broader connections between the music, the eating disorder, and their recovery journeys.

Many spoke of the recovery journey as a non-linear process. P6 reflected upon this theme:

> I have this image in my head of an... Eating Disorder [treatment] commercial, like a Viagra commercial. We all blast out the door, frolicking along the property, like, "Yes I'm free!" ... I think there's the notion that when you're discharged, you're cured, and everything's amazing. Through playing this instrument... it was a very subtle change and yet, it's much more peaceful… That's really what recovery is: it's more fluid as opposed to black and white.

P2 also commented on the bumpy nature of recovery. After an improvisation based around the image of a storm, she shared:

> My life has been a storm, but I've been underwater for a long time… The feeling that I had when we were [improvising] is, I'm not underwater, I have skills to ride the waves…It's like living life and expecting that it's gonna be bumpy, instead of being underneath it all the time and not knowing how to get out.

For several patients, music contained the sound of possibilities and a vision for a better future. In listening back to one improvisation, P17 experienced an image of hiking in a jungle. She expanded: "It's tough to get through, 'cause you have to chop down as you go. But it's also really pretty, like, jungles are really beautiful. They're lush, they're green, they're full of wildlife." P17 explained that this image represents what she would "like for [recovery] to be." Like exploring a jungle, she described, recovery as "tough" and as having "beautiful parts – in it, but also at the end of it." P17's image is striking, both in her vision for the beauty possible for her in the future, but also within her insight that though "it's tough to get through," beauty exists along the journey.

Music, emotional expression, and emotional regulation

The second theme that emerged through the qualitative analysis pertained to music's ability to *support* participants in their recovery. Patients identified that music-making acted as a vehicle for emotional expression and a useful medium for shifting away from or staying with difficult emotions.

Expressing and shifting emotions

Co-creating music allowed participants to express emotions and later, through visual art or verbal processing, to better understand these emotions. P2 described music therapy as an "outlet" and shared, "It was my highlight every week for trying to sort through how I was feeling, 'cause I've been going through a lot." P4 reflected on the emotions that surfaced during sessions: "I released the emotions I was suppressing, so I often left more upset than I was when I came, but it was good because then I was able to like, use skills... instead of just keeping it repressed." Though participation in therapy provoked challenging emotions at times, "in the long term it made things better… It enabled me to deal with the sadness instead of not knowing why I felt sad" (P4).

At times, the group explored shifts in emotion and mental states directly through referential improvisations. In one example, P6 chose to explore shifting from "busyness" to "calm" through an improvisation that the group supported her through (see Recording 1 – "Group 1, Session 4, Emotion Shift").[2] At other times, shifts in mood happened unexpectedly. Several participants described feeling "scattered" before entering music therapy, and afterwards feeling more "grounded" or "calm." P16 described, "I'd always go [to music therapy] anxious and tired. And then I'd leave feeling more hopeful and... happier." After a mindfulness experience involving the singing bowl and humming, P13 shared, "I felt really vulnerable and frustrated when I came in… [I'm] a lot more grounded now". P14 stated, "I felt depressed when I came in. And now I feel very comfortable. The [improvisation]... reminds me of how close me and my brother were. It brings really good memories... It was nice, 'cause I kinda needed some sort of pick-me-up". In this instance, imagery and memories evoked by a particular improvisation reconnected P14 to a significant relationship in her life and elevated her mood. Following one activity in which participants drew while listening back to a recording of a group improvisation, P14 drew a crib and explained, "I felt like [the music] was something that you'd put on in a baby's room… to get them to sleep. It brings me a lot of calmness and feelings of safety… [It's what] I need right now." The musical and visual outlet provided her with the opportunity to identify and fulfil her need to feel safe and calm.

In another instance, after an instrumental improvisation in which members emulated the ebb and flow of a storm, P9 commented that the middle of the storm was "anxiety-provoking" but that there had been a "controlled coming down", reaching an ending that felt "euphoric". P7 described feeling "joy and awe" when listening to a group improvisation exploring the theme of past, present, and future (see Recording 2 – "Group 2, Session 2, I Was, I Am, I Will Be"). This was echoed by several other participants after listening back to improvisations; they noted that while playing, they had been so focused on themselves that they had not been able to hear, or fully appreciate, the full group sound.

Staying with challenging emotions

Engaging in improvised music-making was a first-time experience for all participants. Many group members described feeling vulnerable, uncomfortable, or anxious during music-making. Along with our reminders that there were "no right or wrong notes" in music therapy, we encouraged participants to observe their own thoughts and feelings as they arose, which often included perfectionist and repetitive self-judgements. P14 described "sitting through" improvisations and explained: "I think the more you sit through it the more you become comfortable with being uncomfortable… and you eventually [will] not be uncomfortable anymore. And be able to enjoy those moments that are meant to be enjoyed."

P2 described the parallel between feeling vulnerable in group improvisations and other aspects of her life: "The eating disorder... and your job keeps you focused on something else that you really don't allow yourself to be vulnerable." She identified allowing herself to "be totally vulnerable" as a goal, "and not fighting it, which is what I've done my whole life, is suppressed everything." Group music-making allowed her to explore feeling vulnerable in a safe and supportive environment. P21 shared wanting to be able to "let go and fall" within the music. She related a group improvisation, which

[2] All recordings are available as supplementary material on the website of *Approaches*.

deliberately moved from more to less structure, to her recent experience trying rock-climbing (see Recording 3 – "Group 3, Session 3, Structure to Freedom").

> The way that we went from having the beat to just doing whatever and hoping that it worked out, felt really similar to when I was at the top and they were like "Just let go!" and I'm like, "I can't!" And then I did, and it was fine.

Group music-making was indelibly linked to emotions for most participants. Participants experienced music as an *outlet* for emotional expression, as a medium for *desired shifts* in emotions, as well as an opportunity to *stay with* challenging emotions. Some participants expressed the desire to continue engaging in music-making after the group was over, mainly because of the connections they felt with one another.

Music and connectedness

Social connection, the third theme from the qualitative data, was strongly highlighted by all three research groups. Participants recognised that group music-making invited and sustained connections with one another in unique ways.

Embodying (Dis)connections

Participants often observed that their musical experiences symbolised and embodied their connections to one another. For example, after listening back to her group's improvisation based on the theme, "I Was, I Am, I Will be", P11 described: "I felt all warm inside... I could picture a group of women standing tall and proud against something… it felt beautiful and inspirational and like there was such power, strength, and harmony in it." Participants noted feeling personal connection with one another during moments in which the music was perceived to be in sync: "We started low, and got to a really high point…I remember thinking, like, 'This is beautiful,' and looking around at everybody and being just really happy that I was experiencing this with them" (P16). For P15, during a particularly difficult week, she noted, "I feel like I've totally disconnected from everything… It felt good to be in the room with everyone else participating and to know that there are still people around me... I felt more safe than I have in a while." P15 also noted how the continuity of sound, while humming with the group, contributed to her feeling of safety: "I liked that when I had to stop to breathe it just kept going. When my mind started to drift I came back to just the sound."

P2 noted that improvisation could either connect you with others or keep you within yourself:

> You really have to listen when you're doing the improvisations…It takes you out of yourself… When we're in our own self we're only thinking about our own sound and how we're doing... If we're listening to everybody else's sound and trying to find something that complements it, you're actually relating and that is connectedness.

Similarly, P3 noted that "you have to listen to each other… and through that you can tune in to what they're feeling and what they're going through."

P17 identified feelings of "community connection" when the group sang together, and continued, "I was getting... the musical shivers. When the notes really hit well you feel it at the back of your neck." Several other participants also experienced connection while singing. P2 shared, "When I sing by myself I'm not very good but I like to sing with other people... I like the connectedness when we were doing those things, and I love 'Let It Be'... that's my favourite song". P10 said that in contrast to playing the instruments, which felt uncomfortable, "singing the songs was the most positive thing... I think because it was familiar."

Self-consciousness at times presented a barrier to group connection. Several patients echoed P11's observations that in some improvisations, the group did not come together and individuals were focused on their own sounds, "like a bunch of animals at a watering hole." At times, patients' experiences of discomfort with perceived chaos within group improvisations hindered feelings of connection. P14 described one improvisation: "I started to get anxious, because people weren't following the beat… so I just focused on myself, and neglected everybody else because they weren't… sounding like I wanted the song to sound." As noted previously, increased musical structure was helpful at times. P19 observed that structured drumming experiences "felt more supportive and communal" than improvisations in which everyone played distinct instruments more freely; similarly, P7 reflected that drumming "brought... unity and cohesiveness."

Participants noted that music can simultaneously allow for individual voices to be heard while also creating a larger group sound. While listening back to an improvisation, P17 drew an infinity symbol using vibrant and overlapping colours, and described,

> I was trying to get hold of the unity that we were trying to portray…It's still a little bit jumbled in a sense, but not in a bad way… Some sounds here, other sounds there, then a bigger sound kind of encompassing all of the little sounds together.

Along this theme of parts creating a whole, P5 reflected after an improvisation, "Each individual is so important… it's give and take constantly... We're giving to people whether they see us blossom, and notice that, or whether they see us struggling."

Forging distinct connections

Several participants in each group reflected that music therapy had brought them together in different ways from other group programming at the facility, and noted that particular qualities of music had afforded this. For example, P18 described, "We're all in our heads a lot," noting that music-making allowed the group to "let loose and find a rhythm together in whatever way we feel that we need." After an improvisation representing a transition from vulnerability to strength, in which the group had supported P2, P2 described, "To me that's what healing in the community is… I don't feel it there (pointing towards the hallway) the way I feel it here." P7 described "You can see a different side of people here than you would in traditional groups... It brought me closer to some people."

A noteworthy interaction between P16, P17, and P20 took place at their focus group.

> P16: I feel like music therapy brought us a lot closer than other groups… I felt connection every time I left, like, every time I left this room I felt closer to you guys… We were making something together, and that bonds people.
>
> P17: When you think about it, it's the only group where we do that... Everything else is super useful but it's more an individual thing. Like when we're in horticulture we make our own plant. When we're in one of the CBTs [groups], it's like *our* homework. We share, but it's not something that we make together.
>
> P20: Here we make it together. We always say that we heal in community and this is actually healing in community, 'cause we're actually working together and bonding.

Here, in music therapy, they were creating *the same thing* together, which demanded "being in tune with other people" in a different way than "in groups… where people are speaking" (P2).

External factors often affected the dynamic within sessions, sometimes hindering social connection through music, or making it more meaningful. P7 remembered that at one particular session, "we were all kind of low and not into this as much". In contrast, after listening back to one particular improvisation, she reflected, "I had a lot of joy and happiness knowing that we did that... because there can be a lot of tension on the unit."

We move now to presenting the results from quantitative data analysis, which pertains to music therapy's impact upon patients' moods and emotion regulation behaviours.

Quantitative data analysis

The results presented in Tables 1 and 2 are grouped according to analysis first based upon all research participants followed by patient diagnosis. Table 3 further stratifies the analysis by diagnostic group. These results display that patients were better able to regulate their affective and emotional states after participating in four weeks of music therapy.

Pre-post presentation

Paired t-tests were conducted to compare the difference in emotion regulation strategies and affective state before and after four sessions of music therapy. There was no significant difference in difficulties with impulse control before and after music therapy. There was a significant difference in expressive suppression before and after music therapy ($t(16)=2.648$, $p=0.018$), suggesting that participants were less likely to suppress their emotions after music therapy. Additionally, positive affect before and after four sessions of music therapy was not significantly different. Negative affect before and after four sessions of music therapy was found to be statistically different ($t(15)=3.203$, $p=0.006$), suggesting that participants experienced lower levels of negative affect after four sessions of music therapy (see Table 1).

Response to each session

The PANAS measure was collected before and after each of the four sessions. A paired t-test was used to compare the difference in positive affect (PA) and negative affect (PA) for each session (i.e. S1-S4).

There was no difference found for PA or NA after session one and session three. There was a significant difference in scores of PA before and after session two (t(19)=-4.740, p=0.000) and a trend towards a significant difference before and after session four (t(16)=-2.045, p=0.058), suggesting participants experienced increased levels of positive affect after these two sessions of music therapy. Additionally, there was a significant difference in scores of NA before and after session two (t(19)=3.241, p=0.004) and session four (t(16)=2.671, p=0.017) suggesting participants experienced decreased levels of negative affect after these two sessions of music therapy (see Table 2).

Diagnosis

Paired t-tests were conducted separately for participants based on diagnosis, Anorexia Nervosa (AN) and Bulimia Nervosa (BN), to compare the difference in emotion regulation strategies and affective state before and after four sessions of music therapy. Paired t-tests were also conducted separately for participants based on primary behavioural subtype i.e., restricting or binge eating/purging behaviours, to compare the difference in emotion regulation strategies and affective state before and after four sessions of music therapy (see Table 3).

There was a significant decrease in negative affect from before to after four sessions of music therapy (t(10)=3.192, p=0.010) for AN, and the change was not significant for those with BN. When considering primary symptom presentation, participants whose primary symptom presentation was restriction had a significant decrease (t(7)=2.456, p=0.043) and participants with AN approached significance (t(11)=2.084, p=0.061) in expressive suppression from before to after four sessions of music therapy, suggesting an increase in the ability to express emotion after music therapy. There was a significant decrease in negative affect from before to after four sessions of music therapy (t(7)=4.592, p=0.003) and a slight increase in positive affect (t(7)=-2.227, p=0.061) for participants with a primary symptom presentation of the binge eating/purging subtype.

As demonstrated, music therapy is associated with a decrease in negative affect measured by the PANAS, as well as an increased ability to express emotion measured by the ERQ, particularly for participants whose behavioural symptoms are characterised primarily by dietary restriction.

DISCUSSION

The themes, questions, and considerations arising from this study's results are further elucidated in this section. We begin by discussing the complementary nature of the gathered numerical and narrative data, and then explore the study's results in the area of emotion regulation in particular. Finally, we emphasise the music-centred (Aigen, 2014) perspective that was integral to the music therapy sessions themselves, and which is reinforced by the study's results.

Complementary perspectives: Qualitative and quantitative data

This study's mixed methods design provides two distinct lenses through which to better understand group music therapy's impact. For some elements of the study's results, both numerical and narrative data must be considered together in order to understand participants' experiences more fully.

Regarding patient affect, for example, we recognise that although the PANAS scores indicated that participants experienced lower levels of negative affect after four music therapy sessions, there was no significant overall change in positive affect. During check-ins at the beginning of sessions, patients often expressed feeling anxious and uncomfortable upon arriving to music therapy. Therefore,

Paired T-Test	N	Mean	SD	Mean difference	T	DF	P
Pair 1							
Pre ERQ	17	18.00	5.96				
Post ERQ	17	15.47	6.04	2.53	2.648	16	**0.018**
Pair 2							
Pre DERS	16	16.25	5.90				
Post DERS	16	14.13	3.30	2.13	1.491	15	0.157
Pair 3: PANAS							
Pre PA	16	26.06	8.43				
Post PA	16	26.81	11.61	-0.75	-0.238	15	0.815
Pair 4: PANAS							
Pre NA	16	21.06	8.49				
Post NA	16	15.25	5.87	5.81	3.203	15	**0.006**

Table 1: All participants from baseline to end of four music therapy sessions

Paired T-Test	N	Mean	SD	Mean difference	T	DF	P
Pair 1							
Pre PA (S1)	19	27.16	8.32				
Post PA (S1)	19	29.63	8.30	-2.47	-1.362	18	0.190
Pair 2							
Pre PA (S2)	20	21.55	7.38				
Post PA (S2)	20	29.65	8.11	-8.1	-4.740	19	**0.000**
Pair 3							
Pre PA (S3)	16	26.81	9.11				
Post PA (S3)	16	31.13	9.83	-4.31	1.808	15	0.091
Pair 4							
Pre NA (S4)	17	24.29	9.00				
Post NA (S4)	17	27.06	11.28	-2.76	-2.045	16	**0.058**
Pair 5							
Pre NA (S1)	19	21.63	8.69				
Post PA (S1)	19	19.63	8.98	2.00	1.026	18	0.319
Pair 6							
Pre PA (S2)	20	26.30	9.85				
Post PA (S2)	20	20.50	5.39	5.80	3.241	19	**0.004**
Pair 7							
Pre PA (S3)	16	20.81	8.94				
Post PA (S3)	16	17.69	7.27	3.13	1.27	15	0.224
Pair 8							
Pre NA (S4)	17	20.53	8.22				
Post PA (S3)	17	16.00	6.47	4.53	2.671	16	**0.017**

Table 2: All participants' pre and post session PANAS scores

Paired T-Test	N	Mean	SD	Mean Difference	T	DF	P
Anorexia Nervosa (AN)							
Pair 1							
Pre ERQ	12	17.25	6.17				
Post ERQ	12	14.67	6.08	2.58	2.084	11	0.061
Pair 2							
Pre DERS	11	13.91	5.09				
Post DERS	11	13.36	3.04	0.55	0.392	10	0.703
Pair 3: PANAS							
Pre PA	11	25.18	7.88				
Post PA	11	29.45	12.02	-4.27	-1.194	10	0.260
Pair 4: PANAS							
Pre NA	11	23.27	8.17				
Post NA	11	16.18	6.74	7.09	3.192	10	0.010
Bulimia Nervosa (BN)							
Pair 1							
Pre ERQ	5	19.80	5.63				
Post ERQ	5	17.40	6.15	2.40	1.596	4	0.186
Pair 2							
Pre DERS	5	21.40	4.22				
Post DERS	5	15.80	3.56	5.60	1.830	4	0.141
Pair 3: PANAS							
Pre PA	5	28.00	10.22				
Post PA	5	21.00	9.08	7.00	1.340	4	0.251
Pair 4: PANAS							
Pre NA	5	16.20	7.76				
Post NA	5	13.20	2.86	3.00	0.973	4	0.386
Restricting Behaviours (Subtype of AN)							
Pair 1							
Pre ERQ	8	18.25	5.50				
Post ERQ	8	14.13	6.53	4.13	2.465	7	0.043
Pair 2							
Pre DERS	8	17.38	6.44				
Post DERS	8	14.88	3.98	2.50	1.009	7	0.347
Pair 3: PANAS							
Pre PA	8	26.88	9.20				
Post PA	8	21.00	11.16	5.88	1.341	7	0.222
Pair 4: PANAS							
Pre NA	8	17.75	7.72				
Post NA	8	14.13	5.82	3.63	1.163	7	0.283
Binge Eating/Purging Behaviours (Subtype of BN)							
Pair 1							
Pre ERQ	9	17.78	6.67				
Post ERQ	9	16.67	5.68	1.11	1.296	8	0.231
Pair 2							
Pre DERS	8	15.13	5.51				
Post DERS	8	13.38	2.50	1.75	1.101	7	0.307
Pair 3: PANAS							
Pre PA	8	25.25	8.14				
Post PA	8	32.63	9.32	-7.38	-2.227	7	0.061
Pair 4: PANAS							
Pre NA	8	24.38	8.35				
Post NA	8	16.38	6.09	8.00	4.592	7	0.003

Table 3: Diagnostic breakdown: Baseline to end of four music therapy sessions

we can hypothesise that the significant decrease in negative affect could be a function of participants arriving to each session in a state of heightened anxiety, and then gradually becoming more comfortable in the space. Also notable was the fact that, during *each* research group, several patients mentioned the unfortunate Wednesday morning timeslot; music therapy occurred simultaneously to the eating disorders unit "rounds", during which the interdisciplinary team discussed patients' treatment plans and decided who would have particular privileges granted or taken away based upon treatment progress. Many patients shared that they felt anxiety at this time each week, knowing that team members were speaking about them behind closed doors. Undoubtedly and understandably, this external factor impacted patients' affect while attending music therapy and likely impacted PANAS scores. Notably, the unit has since changed the format for their rounds, with patients now expected to attend and participate in discussion surrounding their own treatment progress.

The perspectives that certain patients shared regarding their affect at the end of sessions also provides one potential explanation for the numerical scores gathered. During focus groups, several participants stated that the emotional state in which they left sessions, as captured on the PANAS scale, was distinct from the longer-term or less obvious benefits they experienced from music therapy. For example, P4's insightful description, cited earlier, of having felt sad when leaving music therapy and then processing rather than suppressing this sadness, affirms this patient's commitment to in-depth psychotherapeutic work. It also provides one potential explanation for the fact that the PANAS scores did not always indicate an improvement in affect during sessions. P4's description portrays the way in which narrative data can contextualise numerical data, reminding us to note the wider context of clients' lived experience and recovery journeys as we interpret and integrate the quantitative scores. While recognising the significance of improved affect, we also suggest that music therapy's success cannot narrowly be evaluated upon mood improvement alone, particularly not in the short-term. Despite insignificant PANAS scores, many patients' narrative accounts of sessions provided a nuanced picture in which music therapy indeed played an impactful role in recovery.

Music therapy and emotion regulation

The measures of emotion regulation collected before the first music therapy session and after the final session demonstrated a statistically significant change in expressive suppression for *all* participants, demonstrating that our approach to group music therapy, which focused upon creativity and freedom in music-making, was supportive of participants in expressing and regulating their emotions (i.e., externalising, shifting away from, and staying with challenging emotions). One important distinction is that participants with AN, restricting subtype—the diagnosis associated with the most restrictive behaviours—demonstrated the *highest* decrease in levels of emotional suppression over four weeks.

We propose that a potential area for further exploration would be to design a model of group music therapy focusing on goals to increase emotional regulation and manage or decrease impulsive behaviours. For individuals with eating disorders who display impulsivity, a potential secondary benefit of group music-making could be the development of greater self-awareness and self-control, as group music-making demands listening, turn-taking, and a constant balancing of one's own sound within the

group's whole, in order to create cohesive music. We recognise this as an area for future clinical development and research.

We also recognise that a major limitation of this study was the absence of a control group. We cannot infer causality in our observations of changes in participant affect or emotional restriction. We acknowledge that some of the improvements documented may be attributed to general progress within treatment. This study was also limited in terms of sample size, at 21 participants. We cannot generalise our results, but rather, only observe trends and suggest that there is great potential for future research in the areas of music therapy's impact upon affect and emotion regulation for individuals with eating disorders.

A music-centred perspective

Music naturally affords experiences of structure and freedom, embodying this dialectic within its very nature. When music is too structured, we can become bored, however, when it is too free, we can become lost or disoriented. Participants in our study, with styles of emotion regulation ranging from impulsivity to restriction, provided feedback that they were able to both benefit from music's structure and also challenge themselves to explore music's freedom.

Music can also play a significant role in identity formation and development, challenging the eating disorder that so often begins to define the individual. In our study, participants were able to perform their musical selves both autonomously and in relation to one another (Trondalen, 2016a), using a range of music therapy techniques to enhance and explore self-identity (Pasiali et al., 2020). Lee (2015) suggests that "it is through the creative immediacy of music that clients can translate their world into musical form" (p. 14) and Ruud (1998) states that music is "similar to play…[and] can be seen as a form of transition leading to imagined ways of being" (p. 163). The ability to play in music, experiment, make "mistakes", and communicate without words allowed participants to play with their identities and challenge perfectionism and rigidity through uninhibited self-expression (Pasiali et al., 2020).

Finally, music's social affordances, well-documented both within and outside of the music therapy literature (Cross, 2014; Grocke et al., 2009; McCaffrey, 2018; Small 1998), provided participants with meaningful experiences of social connection. Participants' music-making reflected, contained, and supported their connections with one another in ways they described as markedly different from other group therapy settings; group music-making allowed individuals to "see a different side of people" (P7), "make something together" (P16), and "heal in community" (P20). Though social connections can of course be made and supported in many different settings, music's *unique* potential benefits in this area provide a strong rationale for the provision of group music therapy within inpatient mental health.

Participants' invaluable experiences of social connection through music-making also connected to the other themes that emerged in this research. For example, music's ability to represent aspects of participants' selves and recovery journeys was amplified by the fact that participants heard this representation with and for one another. P6's and P2's insights, described earlier, about the way in which music represented the "bumpy", "subtle", and "fluid" nature of recovery, were made possible by the group; each individual's musical contribution was vital to the resulting music, which facilitated

these metaphors and insights. In tandem, as participants expressed and stayed with difficult emotions through music-making, they witnessed and supported one another doing this. This was indicated in P5's statement: "Each individual is so important… We're giving to people whether they see us blossom, and notice that, or whether they see us struggling." Our development as individuals is interconnected with our relationships, and music provides a unique medium through which to support and witness one another (Mitchell, 2021). In this way, the themes that emerged from this research are interconnected.

CONCLUSION

In its exploration of the impact of group music therapy for individuals with eating disorders, this study seeks to provide compelling rationale to maintain and increase music therapy services currently offered within inpatient treatment. This study also aims to provide a resource for practicing music therapists while prompting allied health professionals to advocate for music therapy's use within treatment.

Participants' descriptions of their experiences resonated with our music-centred recognition that music provides us with experiences that are "essential to well-being and that are uniquely musical" (Aigen, 2014, p. 65). Our participants took risks, many of them exploring sound creatively, messily, and outside of their comfort zones, connecting these sounds to their lives and emotions, and supporting one another throughout the process. Here, participants' narratives provided this study's melody, and their scale responses filled in a rich harmony to bolster their voices. Through its temporal nature, engaging in musical improvisation challenged participants to stay with their emotions and confront perfectionism and rigidity through subtle changes in their playing or singing. The music they made together reflected reality, provided new possibilities, and held and sustained a range of emotions, connecting participants to themselves, to each other, and to new ways of being.

ACKNOWLEDGEMENTS

Firstly, we wish to thank our clients and research participants. You have taught us so much and we are forever grateful for your courage, boldness, and strength. We also wish to thank the past Master of Music Therapy students who co-facilitated many of the music therapy sessions included in this research: Rachel Nolan, Kathleen Skinner, and Stephen Tok.

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APPENDIX: FOCUS GROUP QUESTIONS

Impact of group music therapy on patients with eating disorders

1. What was the most memorable experience for you in the four music therapy sessions?
2. Were there any musical experiences that you did not enjoy? If so, what were they?
3. What musical experience felt most challenging? What do you think made it challenging?
4. What musical experience felt easiest? What do you think made it feel easy?
5. Did attending music therapy affect your relationships with your co-patients in the group? If so, how?
6. Describe the experience of improvising as a group.
    a. What (if any) aspects of this experience did you enjoy and/or find beneficial?
    b. Were there challenges associated with spontaneously creating music? Were you able to overcome those challenges, and if so, how?

7. Describe the experience of singing as a group.
    a. What (if any) aspects of this experience did you enjoy and/or find beneficial?
    b. Were there challenges associated with singing? Were you able to overcome those challenges, and if so, how?
8. Were there any moments where you felt critical towards yourself or your playing/singing during the sessions? If so, when did these occur? Did these thoughts/feelings increase or decrease as the sessions progressed?
9. In what ways, if any, did participating in the group affect your overall mood?

Ελληνική περίληψη | Greek abstract

Ο αντίκτυπος της ομαδικής μουσικοθεραπείας με άτομα με διατροφικές διαταραχές

Priya Shah | Elizabeth Mitchell | Shannon Remers | Sherry Van Blyderveen | Heidi Ahonen

ΠΕΡΙΛΗΨΗ

Η παρούσα μελέτη μικτής μεθόδου διερεύνησε τον αντίκτυπο της ομαδικής μουσικοθεραπείας σε άτομα που νοσηλεύονται λόγω διατροφικών διαταραχών. Στη μελέτη συμμετείχαν 21 άτομα ηλικίας από 16 έως 58 ετών. Μελετήθηκε η ζώσα εμπειρία τους στη μουσικοθεραπεία, συμπεριλαμβανομένης της επίδρασης της μουσικής στη διάθεση και την συναισθηματική ρύθμιση. Τα δεδομένα, τα οποία συγκεντρώθηκαν με χρήση της κλίμακας “PANAS” (Positive and Negative Affect Scale) (Watson et al., 1988), και των υποκλιμάκων της κλίμακας "DERS" (Difficulties in Emotion Regulation Scale) (Gratz & Roemer, 2004), και του ερωτηματολογίου "ERQ" (Emotion Regulation Questionnaire) (Gross & John, 2003), κατέδειξαν μείωση αρνητικών συναισθημάτων των συμμετεχόντων καθώς και μία αύξηση της ικανότητας για έκφραση των συναισθημάτων τους μετά τη συμμετοχή τους στη μουσικοθεραπεία. Τα δεδομένα που συγκεντρώθηκαν από ηχογραφήσεις και μεταγραφές των μουσικοθεραπευτικών συνεδριών και των ομάδων εστίασης [focus groups], προτείνουν ότι, μέσω της κοινής μουσικής δημιουργίας και εκτέλεσης, οι συμμετέχοντες ανακάλυψαν την ικανότητα της μουσικής να αναπαριστά ποικίλες πτυχές του εαυτού τους και της πορείας της ανάρρωσής τους, τη δυνατότητα της μουσικής να τους βοηθήσει να εξωτερικεύσουν, να διαφοροποιήσουν και να ασχοληθούν με τα συναισθήματά τους, και την ευχέρεια της μουσικής να προάγει κοινωνικούς δεσμούς.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

μουσικοθεραπεία, διατροφική διαταραχή, αυτοσχεδιασμός, συναισθηματική ρύθμιση, μικτή μέθοδος

Approaches: An Interdisciplinary Journal of Music Therapy
15 (1) 2023

ISSN: 2459-3338 | www.approaches.gr

ARTICLE

Music therapy as a protection strategy against toxic stress for Palestinian refugee children in Lebanon: A pilot research study

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ABSTRACT

This article presents a mixed methods pilot research study evaluating the impact of music therapy on the emotional and social functioning of Palestinian refugee children from Lebanon aged 7-11. The research aim was to verify the hypothesis that music therapy is an effective therapeutic method in lowering anxiety levels in children suffering from the effects of stress and trauma, and in strengthening their self-esteem and sense of agency, thus contributing to the development of their resilience. The specific geo-political and social contexts are explained, comparable studies considered, and data collection strategies outlined. Narrative data from music therapists is analysed thematically, complementing analysis of statistical data captured using standardised clinical evaluation measures. Findings indicating that music therapy had a positive effect on the children's emotional and social functioning are discussed as part of a broader reflection on possible future developments.

KEYWORDS

clinical music therapy,
Palestinian refugee children,
toxic stress,
case series research

Publication history:
Submitted 16 Sept 2020
Accepted 9 Mar 2021
First published 10 May 2021

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INTRODUCTION

This research aimed to evaluate the impact of music therapy on the emotional and social functioning of Palestinian refugee children aged 7-11 from Lebanon. The research, a case-series involving 23 children, took place within the context of the international cooperation project "Music and Resilience" (Music and Resilience, n.d.). This project was developed by the Palestinian non-governmental organisation (NGO) National Institution of Social Care and Vocational Training (NISCVT, n.d.), "Beit Atfal Assumoud" (hereafter Assumoud) and the Italian community-based organisation (CBO) Associazione Prima Materia (Associazione Prima Materia, n.d.), in collaboration with Nordoff-Robbins Music Therapy, London UK (Nordoff Robbins, n.d.). Funds were made available by Ta'awon Association Lebanon (Taawon, n.d.).

How to evaluate impact in music therapy is a complex and challenging question, even within systems well geared to such processes. The socio-political context of this study renders even the service provision fragile, and deeply affects the life experiences of the children presenting for therapy. These considerations, coupled with the limited sample size, perhaps call into question the usefulness of "standardised" quantitative evaluation means, which are considered an essential part of "evidence-based research" both by Lebanon's professional mental health community, and by the funding institution. The study therefore utilised a mixed methods design, complementing quantitative analysis of data collected via standard tools with qualitative analysis of narrative case studies. The narrative data, written by the music therapists, aimed to tell the stories of some of the children treated, thus casting light on elements of the process that goes on within the "black box" of therapy, but which is typically neglected by quantitative evaluation.

Given the importance attached to context and the reluctance to accept that music therapy is a one-size-fits-all intervention, the next section of this article outlines the contextual background in which "Music and Resilience" operates, describing Assumoud's development of music therapy within its Family Guidance Centres (FGCs), and demonstrating how and why the mental health teams' clinical attention began to focus on the area addressed in this study. This is followed by a review of existing music therapy literature on work within refugee communities, and a section describing the social profile of the sample group. The concept of toxic stress (which will be used as an analytic tool) is then outlined, followed by the framework of the evaluation project, including the methodology and timeline. The various findings from the data are then presented and discussed, and a concluding discussion reflects on possible future implications and developments of this work.

CONTEXT

In 1948, as a consequence of the Arab-Israeli War, hundreds of thousands of Palestinians were forced to flee their homeland (Fisk, 2001, pp.12-47). This conflict, known to most of the world as the "Israeli War of Independence," is defined by the Palestinians as "Al Nakba" ("the catastrophe"). Around

100,000 refugees escaped to Lebanon to find shelter in what were supposed to be temporary, emergency refugee camps set up by the United Nations. Today their descendants are still living as refugees inside these camps, which, in more than 70 years, have become tightly packed, unhealthily overcrowded and under-resourced urban jungles, contained within walls and/or barbed wire fences, patrolled night and day by the Lebanese armed forces, who can close access to and from them at any time. Due to a fatal cocktail of historical events and political idiosyncrasies, the Palestinian refugees of Lebanon (PRL) have never obtained any kind of civil recognition, either internationally, as exiles from their home country without the right to return, or nationally in the host country, as members of civil society. Nor is Lebanon responsible to them as refugees, delegating all provision of primary needs to the United Nations Relief and Works Agency (UNRWA). Thus, this community is constrained to live in "limbo" with permanently denied rights to public health and education, to professional employment, and to permanent ownership of property. As explained by Chaaban et al. (2016),

> Palestine refugees in Lebanon face one of the worst socio-economic situations in the region second only to the Gaza Strip, and their conditions have been deteriorating given the country's weakening socio-economic situation and the prolonged Syria crisis. A little short of two thirds of the PRL population is poor and the discriminatory laws against them hinder their ability to improve their living conditions and livelihoods. (Chaaban et al., 2016, p. 24)

Given the inhumanly prolonged state of dependency of the PRL community, exacerbated over the years by significant population expansion, the humanitarian assistance delegated to UNRWA has proved chronically insufficient. It falls to the many local NGOs to fill the gap in missing services.

The Palestinian NGO Assumoud was founded in 1976 in response to the Tel Alzaatar refugee camp massacre by Lebanese armed forces during the Civil War (1975-90) in order to take care of the hundreds of orphaned children. It has grown to become one of the largest institutions in Lebanon, providing services for the Palestinian refugees and other disadvantaged people living in the camps or close to them. Assumoud centres are situated either inside or in proximity to all the camps and develop community-based activities targeting primarily children and youth, with close involvement of their families and the local community. Assumoud was the first organisation to address mental healthcare provision in these contexts: in 1997 the first Family Guidance Centre opened in Beirut and, as resources were secured, four more centres were opened serving other camp locations in the North and the South of the country. Mental Health (MH) teams are headed by child psychiatrists and comprise psychologists, social workers and other therapists (speech, motor, ergonomic, psychotherapists). In 2012, in collaboration with the Italian CBO *Prima Materia*, within the context of the international cooperation project "Music and Resilience" (M&R), music therapy was introduced as a complementary treatment. Training in psychodynamically informed improvisational music therapy was given to a group of 14 social workers, psychologists and other therapists, and this was followed up each year with further training and regular supervision of their clinical work, which was also monitored and discussed in the respective FGC MH teams. Two of the authors of this study, Liliane Younes and Mohamad Orabi[1], were sponsored to enrol in the Music Therapy Diploma course in Assisi, Italy,

[1] Mohamad Orabi was sponsored by the Italian NGO "Ulaia ArteSud" (ULAIA ArteSud onlus, n.d.).

graduating in March 2019, thus providing Assumoud with internal professional resources in this discipline.

From the beginning of the programme, the M&R music therapy team supported clinical work with monitoring, evaluation and research, published internally (Parker, 2013, 2015) and presented at MH and music therapy conferences. The clinical population addressed in these studies was highly heterogeneous, with no standardisation of age, clinical profile, or cultural origin. For example, as a consequence of the Syrian crisis, Assumoud's MH clinics were receiving high numbers of newly arrived refugees, and all programmes were adapted to offer an immediate response to the ever-increasing waiting lists. The music therapy programme was no exception, and from 2013-2014 short-term group therapy sessions were set up as a first intervention for these children, whilst maintaining individual treatments for children referred after assessment by MH specialists. Despite the pronounced diversity of cases, detailed data was collected by the music therapists, from other relevant MH specialists and from the children and their families. Clinical observations and evaluation results were considered critically, alongside reflections from the service users and their parents. A high proportion of this very varied data indicated that music therapy had beneficial effects for the children. All professionals involved agreed that further, more controlled, and standardised research needed to be done. This present study represents a first attempt to respond to this need.

COMPARING NOTES: LITERATURE ON MUSIC THERAPY FOR REFUGEE POPULATIONS

Within the growing literature of the last 20 years regarding music as a medium for social care and change, a small but significant amount of research has addressed music therapy specifically with refugees. Zharinova-Sanderson (2004) and Orth (2005) wrote about their respective music therapy work with adult refugees and asylum seekers, using a variety of approaches, both with groups and individuals. In Orth's study of "S" (a traumatised Liberian refugee), the technique of songwriting was highlighted as a powerful agent of organisation and structure. The significance of songwriting also emerged for some of the young Palestinians in the present research, as the case study narrations of children "P" and "N" will show (see section "Narrative data: Case studies).

Other studies have addressed music therapy with young refugees, through a variety of frameworks. Hunt (2005), for example, presented an action research project of short-term group music therapy within a school setting with adolescent refugees. Tyler (2002) illustrated the Nordoff-Robbins model through a case study of a severely traumatised refugee boy. Pavlicevic (2002) also referenced Nordoff-Robbins' concept of "the music child" (Nordoff & Robbins, 1977) in her evocative study of music therapy work with traumatised children from marginalised communities in South Africa. Although these children were not refugees, strong parallels can be drawn between the refugee camps of Lebanon and the South African townships, which were "developed by the apartheid state as part of the policy of 'separate development,' to be inhabited by black people, and generally lacked basic infrastructures such as electricity, tarred roads and sanitation" (Pavlicevic, 2002, p.113). Similarly, the South African children's plight closely resembles that of the Palestinian children in this study; they were described as lacking "basic nurturing, thanks to fragmented families […] or poorly resourced community structures that undermine their parents' capacities to be present emotionally" (Pavlicevic,

2002, p.111). Their trauma was understood within a framework of "cumulative build-up of stress" (Pavlicevic, 2002, p.110).

Jones et al. (2004) were concerned with intercultural issues in developing music therapy in Australia for recently arrived Sudanese refugee teenagers and illustrated, through case studies, the efficacy of music in contributing towards protection against emotional, social, behavioural and learning problems.

Lang and McInerney (2002) wrote about the work of the Pavarotti Music Centre in Bosnia-Herzegovina following the break-up of the Yugoslav state (1991-96). Their series of case studies illustrated differing aspects of clinical work with traumatised children, most of whom were refugees within their own country. In 2009, one of the founders of this project, Nigel Osborne presented further research with reference to the framework of post-traumatic stress disorder (PTSD). Osborne developed a biopsychosocial paradigm, borne out of extensive neurobiological research, for music and arts interventions with children suffering the effects of conflict.

Recent research on the island of Chios, Greece, showed that one-off music therapy group sessions for refugee children in transit could support social interaction and stress reduction, providing some protection for the children in this disorientating phase (Akoyunoglou-Christou, 2016), and research on the combination of music therapy and cognitive behavioural therapy in reducing PTSD in Syrian refugee children has been conducted in Jordan (Damrah, 2014).

Two projects, developed specifically within Palestinian communities, are of particular relevance. Project Bethlehem (Coombes, 2011), developed by Music as Therapy International and recently in collaboration with Musicians without Borders (Music as Therapy International, 2021), runs in the West Bank of the Palestinian Occupied Territories, training local staff in schools, refugee camps and care settings in the use of therapeutic techniques in music for vulnerable children and adults. Meanwhile in Lebanon, in collaboration with the same local Palestinian NGO engaged in "Music and Resilience," Assumoud, the Norwegian Academy of Music has been working since 2002 to develop a robust community music project in "Rashedie" refugee camp in Tyre (Storsve et al., 2010). The results of this very successful project, which show clearly the benefits that music involvement brings to the youth of the camp, were certainly important in influencing the request of Assumoud to Prima Materia to extend music resources to the clinical area in the FGCs.

With few exceptions, these important contributions to understanding how music therapy can support and assist refugees are characterised by qualitative methodologies. It is not surprising that very little quantitative, clinical music therapy research with refugee children has been documented. In order to produce standardised data for quantitative analysis, a certain stability of infrastructure is necessary. "Stability" is not normally an attribute of refugee status, which is associated with transience of life conditions. Many of the environments in which music has been introduced for refugees specifically as a protection factor against the risks of trauma, deprivation and marginalisation, have been characterised by the unpredictability of conflict and forced migration, within a framework of gradual social integration however slow and painful this process may prove to be. Contrastingly, the uniquely "stuck" situation of the Palestinian refugees in Lebanon has created, in 72 years, an "exploitable" panorama of well-established infrastructures such as the Assumoud MH clinics, with reliable medical teams, able to guarantee the necessary support for consistent and articulated data collection, permitting focussed analysis of measurable values.

THE PERSONAL, SOCIAL AND DEVELOPMENTAL IMPACT OF BEING A REFUGEE WITHIN THE CAMPS

It is easy to write political histories or to document the evolution of services without pausing to consider the personal impact of being a refugee by heritage, as is the case for all the children participating in this study. They are third or fourth generation Palestinian refugees in Lebanon (PRL). Their ancestors fled their homeland in 1948 and their families have lived in or around refugee camps ever since. Unsurprisingly, this significantly limits opportunities for flourishing amongst young people, and is frequently manifested in the form of identifiable mental health conditions (Afifi et al., 2011; Atallah, 2017; Mohamed & Thomas, 2017). Here we illustrate this by means of the presenting stories of the four children whose music therapy processes will be considered later:

> P is 7 years old, the second of three children, and lives in a camp with his siblings, parents, a paternal uncle and a paternal aunt. According to P's mother, considerably younger than her husband, the marriage is unhappy, with much strife, and her sister-in-law interferes with the upbringing of the children. Furthermore, she suspects her brother-in-law of being homosexual, causing her great fear for possible abuse of her sons, and resulting in her overprotection of them. At the same time, she seems to project her general dissatisfaction with life onto her second child, who clearly does not live up to her expectations. She complains about his behaviour and describes him only in negative terms; she sees no progress in him and is incessantly demanding of him.
>
> N, a boy of 10 years old, is the youngest of five children, with four older sisters. The children and their mother suffer from chronic domestic violence perpetrated by their alcoholic father. Two of the sisters married extremely young, partly in order to escape this situation, but one has subsequently divorced and returned home. N has become increasingly withdrawn and fearful, isolating himself from his peers and refusing to go to school.
>
> O is 11, in grade five at her local UNRWA school. Her mother suffers from depression and is in treatment with the FGC psychologist, who also assists O's younger brother for learning problems and conduct disorder. O's family had lived for a period in Syria; when the Syrian crisis began, mother and children returned to Lebanon, whilst the father remained in Syria and then disappeared. The family receives no news from him and does not know where he is, or if he is still alive. Back in Lebanon, the family faces extreme financial hardship. O's mother tries to make ends meet, working sporadically in temporary casual jobs, but the family depends on NGO charity sustenance. The family lives in one room, often having to share it with an uncle who has schizophrenia and whose behaviour creates much distress for O.
>
> T is 7 years old, the third child in his family. His father was born in another Arab state and came to Lebanon when he was 20. His attempts to leave Lebanon again during the 1990s failed, due to his status as a Palestinian refugee, causing him ongoing disappointment and frustration. He has never given up trying to

> leave Lebanon with his family. Neither of T's parents completed their education. His father finished only primary school, before beginning to work; he hated school and describes himself as "stupid." At 18 years old, T's mother enrolled on a vocational training course, where she met her future husband, whom she describes as "a dreamy fiancé with unrealistic ambitions." Her family agreed to her engagement, relieved that she would not remain single like her aunt. The newly married couple lived for a short period in the Beirut suburbs, but economic hardship forced them to resort to accommodation inside one of the nearby refugee camps. For T's mother, this situation shattered her dreams of a better life and she has resigned herself to "living with a man walking in the void." T's mother speaks of her husband's rough handling of the child, relating this to T's father's own childhood experience of a cruel father: "he speaks to T in the same humiliating way." Her own expectations regarding her son's capacities are however equally negative, summed up as: "I think my child is like his father."

From these stories, it is evident that the referrals to the Assumoud MH teams are far from clinically straightforward: these children's situations cannot be considered without reference to their living conditions and indeed to the social and geo-political circumstances in which they find themselves growing up. Just as identity narratives are crucial to "being Palestinian," so these flow into the work of music therapy and it would seem inappropriate to impose an external model of evaluation which excluded consideration of this. Thus, it was decided to adopt an approach to evaluation which incorporated quantitative elements which corresponded to areas of particular interest and concern to the service itself, whilst also honouring the therapy stories narrated by the music therapists as case studies.

AN ANALYTIC FRAMEWORK – FROM PTSD TO TOXIC STRESS

It was clear from the outset that data analysis would be aided by the use of a conceptual framework relevant to the situations of these children. Post-traumatic stress disorder (PTSD) was first defined in relation to the psychological state of American military servicemen returning from the horrors of the Vietnam War (1955-75). It has been one of the most commonly used frameworks with reference to Lebanon as a post-conflict zone, perhaps due to Western psychiatry's dependence on DSM and ICD classifications. PTSD refers to a situation caused by a trauma which is no longer ongoing for the person. In 1992, Judith Herman's seminal book "Trauma and Recovery" provided strong clinical evidence that the symptoms described in PTSD were relevant not only to "institutionalised" forms of terror, but also to the domestic and intimate violence of abusive home life. In 2010, Miller and Rasmussen published an article "War exposure, daily stressors, and mental health in conflict and post-conflict settings: bridging the divide between trauma-focussed and psychosocial frameworks," suggesting that "trauma-focussed advocates tend to overemphasise the impact of direct war on mental health and fail to consider the contribution of stressful social and material conditions (daily stressors)" (p.7). Renos Papadopoulos (2007) has also contributed to the epistemology of trauma-focussed intervention with refugees, developing the "Trauma Grid," which enables a more comprehensive and flexible understanding of each person's unique way of reacting to traumatic events.

Subsequent research has confirmed Herman's (1992) exposition of the adverse effects of violence, be they the result of direct armed conflict or of home abuse and insecure, uncaring living conditions, leading to the adoption of terms such as "early childhood adversity and toxic stress" (Shonkoff et al., 2012) and "early life toxic stress" (Johnson et al., 2013). The term "toxic stress" defines the signs and clinical symptoms provoked by prolonged and profound adverse life conditions, as opposed to the stress of past traumatic experiences. It is "toxic," because of its negative biopsychosocial consequences, signalling its salient difference from "healthy" stress, which is defined as a normal, physiological component of developmental problem-solving.

The Adverse Childhood Experiences (ACE) research (Felitti et al., 1998), involving more than 17,000 adults in a retrospective study, indicated adverse childhood experiences to be amongst the most important determinants of health and well-being. Felitti (2002) used the metaphor "turning gold to lead" to express the tragic transformation of "a normal newborn with almost unlimited potential to a diseased, depressed adult" (p. 45). ACE categories, differentiating types of personal abuse (physical; psychological; sexual) and home environment dysfunctions (presence of substance abusers; mentally ill, depressed or suicidal family members; family members imprisoned; mother treated violently; parents separated, divorced or lost), permitted the scoring of participants in order to rate their exposure to adversity. All the children described in this study have an alarmingly high ACE score. ACE effects are played out at a biological level in a critically sensitive period of life, shaping the development and calibration of the neuroendocrine-immune network, with resultant increased vulnerability to a large spectrum of subsequent pathologies (Johnson et al., 2013). More recent research confirms that incidence of conduct disorder, depressive disorder and general anxiety disorder is considerably higher in adolescents with histories of childhood maltreatment than in more securely raised youth (Greger et al., 2015).

These studies provide a clinical framework for addressing the symptoms manifest in the children included in the present research, who are not living in a conflict zone, but are the victims of the "basic fault" (Balint, 1992) induced by conflict and trauma experienced by earlier generations of their families, and who are living in conditions characterised by incumbent and chronic "daily stressors." They are indeed victims of toxic stress, which is situated at the pathological extreme of the stress spectrum.

RESEARCH METHODOLOGY AND DATA COLLECTION

The research protocol for this study was developed, defined and approved during the early part of 2017, by the three Assumoud mental health (MH) teams of the FGCs involved, located in Beirut, Sidon and Tripoli.

Since Assumoud's mission is to offer any resources available to children in need, the creation of a control group, where access to music therapy would have been denied, could not be ethically justified. Instead, the study was designed as a "case series" (Gold, 2015). The research aim was to monitor the impact of music therapy on the emotional and social functioning of Palestinian refugee children from Lebanon aged 7-11, in order to verify the hypothesis that music therapy is an effective therapeutic method in lowering anxiety levels in children suffering from the effects of stress and trauma, and in strengthening their self-esteem and sense of agency, thus contributing to the development of their resilience.

Two objectives were set for the study:

1. to test the hypothesis through the collection and analysis of controlled, standardised data and narrative data.
2. to develop and consolidate the MH teams' clinical experience, in music therapy intervention to date, with Palestinian refugee children in Lebanon.

The following inclusion criteria were adopted for the research study: children aged 7 to 11 years of age (at closure of the study), without reference to gender; from Palestinian refugee families historically from Lebanon (Palestinian refugee families from Syria were excluded); children with preliminary diagnoses limited to disturbed emotional and social functioning, without comorbid organic conditions; receipt of a Participation Information and Consent Form for each child, signed by both parents, if available, and, if not, by at least one parental figure or guardian.

The first 30 children presenting at the Assumoud FGCs, who met the research criteria and were referred by the mental health teams to music therapy services, were to receive 16 thirty-minute individual sessions each, at weekly intervals. A comprehensive psychiatric and clinical assessment was completed during the week before therapy started and within two weeks of closure of therapy, using both global and categorical scales, following a psychiatric evaluation and diagnosis based on the DSM-5 (American Psychiatric Association, 2013). This included the following elements:

- Child Behaviour Checklist/6-18 (CBCL) (Achenbach & Rescorla, 2001): the CBCL/6-18 (2001 revision, for use with children 6-18 years old) is a component of the Achenbach System of Empirically Based Assessment, for identifying behavioural and emotional difficulties. The evaluation scores eight syndrome scales, addressing mood, mental and attention abilities and behaviour, grouped according to internalising or externalising factors, and referring to relevant DSM diagnostic categories. The checklist, which has inbuilt flexibility with respect to differing cultural/societal norms, charts observations made by one of the child's parental figures in answer to 113 questions, rated on a three-point Likert scale (absent / occurs sometimes / occurs often). Percentage scores are expressed for each syndrome domain, for internalisation and externalisation factors, and as an overall average.
- Children's Global Assessment Scale (CGAS) (Shaffer et al., 1983): CGAS is carried out by a clinician for children between the ages of 6 and 17 and assesses a range of elements indicating social and psychological functioning. The assessment is expressed as a single percentage figure, along a constant spectrum of ten categories, where 1-10% indicates poorest level of functioning and 91-100% the best.
- Visual Analogue Scale (VAS): VAS are psychometric scales used to measure the intensity or frequency of determined signs or symptoms. In this study, it was used to measure indicators of emotional and social functioning, based on DSM-5 relevant criteria (American Psychiatric Association, 2013). FGC psychiatrists chose, for each child, the three, and in one case four, most salient indicators of emotional and social functioning.

The first, second, fifteenth and sixteenth music therapy sessions were video recorded, thus enabling evaluation of a preliminary and a closing session for each child using a specific music therapy tool, the Individualized Music Therapy Assessment Profile (IMTAP) (Baxter et al., 2007). This allows

for the assessment of observable behaviour during improvisational music therapy activity over a range of up to ten functional domains, three of which – emotional, social and musicality – were selected as most relevant for this study. Each domain includes "fundamental" observations, followed by more detailed "subdomain" indicators. Scores are computed in percentages, and expressed for each sub-domain separately, or as overall domain averages.

Complementing this statistical data, the protocol also required brief narrative case studies to be written by the music therapist working with each child, as a means of preserving focus on the process of the therapy itself and providing some insight into the experiences offered by the therapy, as perceived by the therapists involved. The therapists' narratives provide data complementing the structured interviews of the CBCL, which gave voice to the parents' views of their children as they progressed through therapy. Four of the case study narratives were selected randomly, as a sample to be included and analysed thematically.

Data was collected between June 2017 and October 2018. During this period, a high proportion of Palestinian refugee families from Syria were seeking help in the FGCs: their children did not meet the inclusion criteria. In total, full data was collected for only 23 children who met all the inclusion criteria. Both Ramadan and periods of social unrest and instability impeded families attending treatment centres for long periods of time, thus making it impossible for sessions to be held on a weekly basis. These factors prolonged the period of data collection for many of the children in order to maintain the standard 16 music therapy sessions each.

During 2019, the IMTAP video evaluation was carried out "blindly" by an external team of music therapists in Italy. Prior to evaluation, the four members of the team met for training in the use of IMTAP, including repeated test-evaluations, until a satisfactory level of standardisation in evaluation measures had been achieved. By the end of 2019, all statistical data was complete and ready for analysis, which was carried out by the research team at Nordoff-Robbins Music Therapy, London, in the first months of 2020.

NARRATIVE DATA: CASE STUDIES

P's music therapy pathway

P was referred for music therapy by the team speech therapist, concerned about his extreme shyness and his difficulties with verbal expression, compounded by stuttering. In the early sessions, P presented as a distinctly hesitant child, reluctant to take initiative, lacking spontaneity, manifesting in transference of his fear of soliciting negative reactions from the therapist. Playing together at the piano, he focused on "his" part of the instrument, his own space, concentrating on his own musical expressions, which were disorganised with no rhythmic structure, not daring to approach or engage with the therapist's space. His response to verbal exchange was limited to short phrases and he needed considerable encouragement. His communication difficulties were manifest in his inability to discriminate or manipulate a simple pulse or rhythm, indicating a state of deregulation of his internal time and space. The therapist mentalised[2] this within the context of the primary relationship lacking

[2] Within the framework of the music therapy model applied, mentalisation is the process by which the therapist assigns significance to dynamic elements emerging during the therapy process.

in synchronisation and attunement. She limited her actions to supporting and confirming his music, trying to match his uneven tempi and erratic expressions, without judging or making demands. Gradually, his way of playing changed, allowing brief moments of meeting in a common, fleeting musical structure. He began to take initiative, to widen the space between his hands on the keyboard, and to encroach on the therapist's part of the piano, entering her "space"; showing a clear competence of attention and awareness of presence, he began to mirror her phrases. This was interpreted as a first step forward in the therapeutic relationship, an indication of growing trust.

As treatment progressed, P's body movements and his music acquired more freedom within the external space, reflecting a transformation within his internal being. He began to explore higher intensities on the percussion instruments and his playing became more lively and confident. He engaged physically with his music, using intensity and speed to discharge a compressed internal energy, in a kind of "explosion" of physical movement, which he had maybe never been able to explore. The therapist's reception of these expressions evoked an intense need to communicate many repressed feelings and emotions and she responded to his constant need for positive feedback. His repetitive, insistent playing on the keyboard had lost its submissiveness, freely releasing his shyness, his anger and his frustration.

This increased physical relaxation and ease in expression was evident also in his verbal exchanges, indicating the emergence of a functional physical and psychic flow. His music maintained a lack of formal regularity of space and time; he was not able to work within a clear structured frame or to use a melodic line, despite the therapist's attempts to provide these elements. In the concluding sessions, however, P and the therapist managed to invent a song together about his desires; this represented a highly significant achievement, and he was proud of having "produced" something.

N's music therapy pathway

N was referred to the FGC for psychological and cognitive assessment and diagnosed with moderate depression. Discussion in the MH team meeting confirmed a preference to avoid using medication, and his referral to music therapy was decided, setting three main objectives: providing N with a safe environment; reducing his depressive symptoms; supporting him to express his emotions.

During the early sessions, N behaved paradoxically; on the one hand, he seemed to be physically in a catatonic state, slow, unreactive, with motor coordination difficulties, on the other, as soon as he began to play an instrument, he would stop, as if he had done something wrong, and move to a different instrument. The therapist sensed his transference of fear, guilt, frustration and uncertainty, and felt that N was searching for his identity.

Physically blocked, unable to express or modulate his emotions, N manifested a meaningful "stuckness" in his dissociated way of existing in the music therapy space, reflecting how he had learnt to survive in daily life. Being together in the session consisted of the therapist's support of N's behaviour, without opportunities for authentic "meeting". The therapist hoped that at least N was aware of the safe place for him.

In the fourth session there was a noticeable change in the quality of the musical exchange. Whether playing alone or together with the therapist, N began to reference the other's presence more often through eye-contact; this availability to be in relationship was reinforced by a new tendency to talk about things which were annoying him outside the sessions. Collaborative improvisation now became possible, highlighting N's tendency to a preferred passivity, certainly non-aggressive, cooperating with the therapist by following his lead; for the therapist, this style of being in relationship was evocative of a "shadow".

Having established a trusting working alliance, the therapist began to leave more space for N's musical expression. N was reluctant to take initiative; his own music was ostentatiously formless, a-rhythmic, uncontained, and in "shadowing" the therapist, he seemed to have difficulties with attention and memory, finding it hard to repeat even a short musical idea.

During the final sessions, the therapist embraced N's musical being as it was, and concentrated on investing in the quality of safeness and enjoyment of the music therapy environment. N began to smile more often, and spoke freely and confidently of his preference for the percussive instruments. He also began to use his voice to sing in the final sessions, inventing and developing his own song.

Unfortunately, despite indications that N was reacting well to this treatment, extenuating circumstances prevented its extension. Before ending, the FGC was able to discuss plans with N's parents for enrolment in a special school where he could be followed in order to reinforce his learning capacities and recuperate his school career.

O's music therapy pathway

O was brought to the FGC by her mother who was concerned about her daughter's behaviour: her overall sadness and withdrawal; her unruliness, both at home and at school; and her frustration, which was expressed through inappropriate behaviour towards her two older sisters (14 and 16 years old), and violence towards her younger brother (8 years old).

O's diagnosis by the FGC psychiatrist defined a moderate depression with impulsive traits and she was referred to music therapy. Her behaviour within this environment was never unruly, oppositional or inappropriate; she was compliant, cooperative and respectful of the musical space and instruments. However, her depression was clearly manifest in her closed posture, her restricted movements and gestures, and her lack of initiative. Her preferred instruments were guitar and piano; in the early sessions, she would play them with a blank expression on her downturned face, finding a rhythmic and melodic pattern of notes in a soft intensity and then repeating it continuously, in a suspended and lethargic way. Despite being receptive to the therapist's invitations to play, her music was in no way interactive at this stage; the therapist limited his response to an unconditional and undemanding support, accompanying her musically as a sign of his presence and availability. After the end of each session, a further ten minutes were dedicated to verbal exchange, offering a space for O to speak about things that caused her discomfort.

From the fourth session onwards, O began to show signs of trusting the music therapy environment and her therapist; it was perhaps significant for a young girl who did not know whether her father was alive or where he might be, that the therapist was male. She began to develop her listening skills in the improvisations, adapting her playing to answer the therapist's phrases, and

learning to take turns. Her musical abilities grew and, with them, her communication skills. Her newly emergent strengths supported a growing capacity and availability to be in an interactive, communicative relationship with the therapist.

These more adaptive behaviours indicated a more serene psychological state, as O's depressive symptoms began to recede. Her mother reported that her behaviour had become much more adaptive and appropriate, both at home and at school, where she was at last making friends and had even been elected as the class representative. This short period of treatment, undoubtedly reinforced by an involved and cooperative mother, impacted positively on O's inner state and supported the emergence of her competence to find more adaptive strategies to her life situation.

T's music therapy pathway

T's mother brought him to the FGC, complaining about his low school achievement, his agitated behaviour and his aggressiveness. The psychiatrist diagnosed ADHD combined presentation and disruptive disorder; he was referred to music therapy.

T's music therapy pathway was continually threatened by interruptions due to absence for various reasons. The emergent characteristics were his extreme agitation, his need to play continuously and his tendency to transgress any boundary set by the therapist. For many sessions he behaved as if trying to find his own space. In the second session, he used four beaters to build a square on the mat; this was interpreted as a need to define a space that he could not yet integrate, in relation to the therapist. His unending movement inside the musical space and his ubiquitous distraction reflected his emotional distress, his internal anxiety, instability and affective dissociation. Brief moments of communication occurred in the synchronicity of short rhythmical beats; moments of approach emerged through musical exchanges, such as his occasional mirroring of a phrase offered by the therapist, but these did not last for long. He had great difficulty in starting and ending a defined task, even if very short. He moved incessantly in and out of the musical space, reflecting a disintegrated self and a despair with respect to unity. For T, the act of communicating was fraught with dangers, and his astonishment at the new sensations of being "seen, heard and cared for" was evident. The new model offered by the therapist was very different from the reactions he had learnt to expect from his parents; the therapist's presence, her ability to hold him, and not to punish him at each "inappropriate behaviour" slowly encouraged him to risk the new sensation of trusting. He began to explore this relationship, sensitive to the attention dedicated to him, with the discovery that he could manage verbal exchanges well, so that he felt able to share a song which he had learnt at school.

During the course of music therapy, T's "normal" home life continued. He arrived for the third session with both hands bandaged; his father had burned his hands as a punishment for ruining some photographic work. Despite his bandaged and painful hands, he tried to play, but soon gave up, manifesting boredom and lack of interest in the therapist's proposals. Often, he remained silent and non-reactive, forcing the therapist to think for him, observing, without words. He frequently ignored the therapist's music, communicating his need to be seen by sitting on, or stepping on the instruments. He demonstrated that the therapeutic space was not enough for him. On many occasions he could not cope with being in a face-to-face position, sitting laterally to the therapist. Repeatedly the therapist's music met no reaction from the child, despite the therapist's feeling that contact, and trust had been

established.

He arrived at the sixth session with a bandaged head; his brother had thrown a stone at him, causing a visit to emergency services for stitches in his head. In the final session, one of his hands was bandaged again; his mother reported that he had jumped from a high step and broken his hand.

Music therapy perhaps helped T to regain some trust and confidence in a possible caring human relationship, so different from the context of his daily life. This latter situation was clearly a negative factor, which prevented achieving sustained, generalised, positive results. Music therapy represented a single positive intervention within the context of an ongoing, severely problematic environment.

QUALITATIVE ANALYSIS AND FINDINGS OF NARRATIVE DATA

The descriptions of music therapy pathways were provided by the music therapists, whose ways of thinking, of interacting with each child, of experiencing what happened in sessions, and even of using language to convey their experiences are all likely to be highly associated with their personal, cultural, professional and musical norms, as well as their experiences of training and supervision. As such, this data provides an insight into the processes within the music therapy room from the perspectives of the therapists (one Lebanese and the other a Palestinian refugee themselves). Given the imposition of non-indigenous standardised tools for quantitative data collection and analysis, the local voices telling clinical stories demand to be heard. Nevertheless, it must be accepted that the experiences of the therapists do not necessarily describe or map onto that of the children in each case: rather these must be treated as one-person "insider accounts" of a shared process.

Thematic analysis (Tsiris et al., 2014) of these narrations reveals two main groups of themes: the first concerning the therapeutic process and the second the role of the music therapy room in the process. Themes addressing the therapeutic process include: 1) the characteristics of the children in the early stages of their music therapy pathways; 2) the thinking and strategies adopted by the music therapists; 3) the changes in the children's musical and social behaviour during their therapeutic journeys. Initially, all the children showed an extreme distrust of the world surrounding them, manifesting fear, and anxiety in all their behaviours. Their reactions differed along the "fight-flight-freeze" spectrum, from inhibited, withdrawn, and lethargic behaviour, to unruly, disruptive and challenging acting out. These attitudes, together with cognitive dysfunctions, particularly of attention and memory, were reflected in corresponding difficulties in musical competence, participation and social engagement. The music therapists reflected on what was happening and adopted consistent strategic responses aimed at welcoming and accepting, showing availability and care, neither demanding nor judging, creating a "safe place" for musical meetings and enjoyment, thus modelling a new and healthier relational style for the children. In their turn, the children responded to this new "way of being with another," manifesting reduced anxiety and increased trust, which emerged in improved motor competence and more regulated hedonic tone, better affective adaptation, improved cognitive skills and musical abilities, and greater relational awareness, motivation, and gratification.

The therapy room was experienced by the therapists as existing in juxtaposition with the outside world. The therapy room was understood not simply as a physical space but also as a location where the therapists could work to provide an experience of safety via personal and musical availability to the children. In contrast, the outside world was felt to be much less predictable, responsive, and

nurturing. In this way the therapy room seemed to provide space for necessary development – whether this was development that had been missed out on for various reasons, or whether this was development which was needed in order to cope with the demands of growing up in an environment characterised by toxic stress. However, the shadow of the external environment fell heavily on the serene oases of the music therapy spaces; in all cases but one (that of O), the narratives remind us of the extreme contingent challenges persisting in the children's lives.

Furthermore, the experienced nature of the room (as a safe space where therapy took place) was configured not simply by what the therapists did, but also by the actions and agency of the children themselves. In other words, the children themselves actively contributed to the creation of the therapy room as a therapeutic space in the ways in which they interacted with the therapist as well as in the uses they made of instruments and musical opportunities. Each process in its own way featured a sense of movement (from isolation or rejection to interaction and responsiveness), albeit in some cases significantly but unsurprisingly hampered by external circumstances. This was evidenced by physical behaviours as well as by new, often experimental, patterns of interaction featuring expressivity, humour, warmth, pride in aesthetic achievement etc.

QUANTITATIVE ANALYSIS AND FINDINGS OF STATISTICAL DATA

Complete quantitative data, as stipulated in the research protocol, was collected for all the children involved. This is particularly significant with respect to the CBCL, an assessment compiled from the parent's answers about their children, as it indicates a high level of cooperation from these primary caregivers, in support of the research study.

The age distribution of the 23 children in the study group ranged from 7 years to 11 years 11 months. The mean age was 8 years 11 months.

The statistical tests on the different variables imply that there was a significant improvement in the pre- and post- music therapy intervention data for all the measures. The discrete steps and test results are outlined below.

Variable Creation

To aid data analysis, the original data was compiled into the variables outlined in Table 1. Whereas variables for CBCL, CGAS and IMTAP were standardised for all children, the VAS indicators were child-specific and therefore treated as separate items, in order to maintain precision.

Paired samples t-test

In order to establish if there was a significant change in the scores from the different psychological measures before and after the implementation of the music therapy intervention, a paired samples t-test was chosen as an appropriate statistical test. This test compares the mean value of the pre- and post- variables and calculates if the difference is significant. To meet the underlying assumptions of this test, the data was analysed for normal distribution and checked for outliers. Normal distribution was checked by looking at the variables' level of skewness and kurtosis. Skewness is "the degree to

which a set of scores, measurements, or other numbers are asymmetrically distributed around a central point" (APA Dictionary of Psychology, n.d.), whereas kurtosis is "a statistical description of the degree of peakedness of distribution" (APA Dictionary of Psychology, n.d.). The acceptable range for skewness is between -1 and 1, while for kurtosis between -2 and 2.

Measure	Variable 1	Cases	Variable 2	Cases
CBCL	CBCL Pre	23	CBCL Post	23
CGAS	CGAS Pre	23	CGAS Post	23
IMTAP - Emotional	IMTAP-E Pre	23	IMTAP-E Post	23
IMTAP – Social	IMTAP-S	23	IMTAP-S Post	23
IMTAP – Musicality	IMAP-M Pre	23	IMTAP-M Post	23
VAS	VAS Pre	70	VAS Post	70

Table 1: Compilation of variables

Variable	Value of skewness	Value of kurtosis
CBCL Pre	-.29	-.55
CBCL Post	-.82	.53
CGAS Pre	.13	-1.04
CGAS Post	.03	-.74
IMTAP-E Pre	.10	0
IMTAP-E Post	-.12	-1.45
IMTAP-S Pre	-.57	1.04
IMTAP-S Post	-.52	-.35
IMTAP-M Pre	.64	-.01
IMTAP-M Post	.51	.34
VAS Pre	-.33	-.8
VAS Post	-.03	-.83

Table 2: Distribution analysis

While five variables were moderately skewed and three variables showed moderate kurtosis, all values fell into the acceptable range and thus normal distribution of all variables was assumed (see Table 2). To check for outliers, the data was transformed into standardised values and as all of these fell into the acceptable range between -3 and 3, no outliers could be detected. Given these results, it was concluded that all variables were fit to be used in the paired samples t-test. The same was consequently applied to each pair of pre and post scores. The results in form of the mean (M) and the

standard deviation (SD) for each variable are given in Table 3. A significant effect of the music intervention can be assumed if the p-value (p) of the paired samples t-test (t) is p<.05. Similarly, a significant correlation (r) between the pre and post scores can be assumed if the p-value (p) is p<.05.

Variable	Pre		Post		T-Test		Correlation
CBCL	M=70.22	SD=6.92	M=65.43	SD=8.33	t(22)=2.58	p =.017	r =.33
CGAS	M=51.09	SD=12.96	M=68.7	SD=14.16	t(22)=-6.15	p =.000	r =.49
IMTAP-E	M=62	SD=16.42	M=72	SD=12.76	t(22)=-2.97	p =.007	r =.41
IMTAP-S	M=48.61	SD=13.35	M=57.65	SD=12.07	t(22)=-2.8	p =.000	r =.26
IMTAP-M	M=19.78	SD=11.07	M=32.17	SD=15.49	t(22)=-5.73	p =.000	r =.74
VAS	M=5.31	SD=2.66	M=4.44	SD=2.31	t(69)=2.04	p =.045	r =-.02

Table 3: Paired samples t-test results

By looking at the p-values for the paired samples t-test it could be inferred that there was a significant difference between the pre- and post- scores of all variables (see Table 3). Therefore, it can be assumed that the music intervention had a significant effect for the different psychological measures.

Furthermore, the two significant correlations in the Children's Global Assessment Functioning and the Musicality score of the Individual Music Therapy Assessment imply that the music intervention had a similarly strong effect on all of the participants for these two particular measures.

Correlation in the IMTAP

As the IMTAP was measured in three domains (emotional, social and musicality), these were checked for correlation in the post-music therapy intervention data collection, by means of bivariate correlation analysis. As the data had already been checked for normal distribution and outliers, only linearity as assumptions needed to be met for the bivariate correlation. This was checked by inspecting the scatterplots of IMTAP-S x IMTAP-E, IMTAP-E x IMTAP-M, and IMTAP-S x IMTAP-M. For linearity, a “straight line” relationship between the variables should be formed. If a line were to be drawn between all the dots going from left to right, the line should be straight and not curved.

As seen in figures 1, 2 and 3, the scatterplots confirm linearity of the data and thus a bivariate correlation test was applied to the variables (see Table 4). The highly significant correlation between the three measures of the Individual Music Therapy Assessment Profile implies that the musical intervention had a nearly equal effect on the emotional, social and musicality measures of each individual participant.

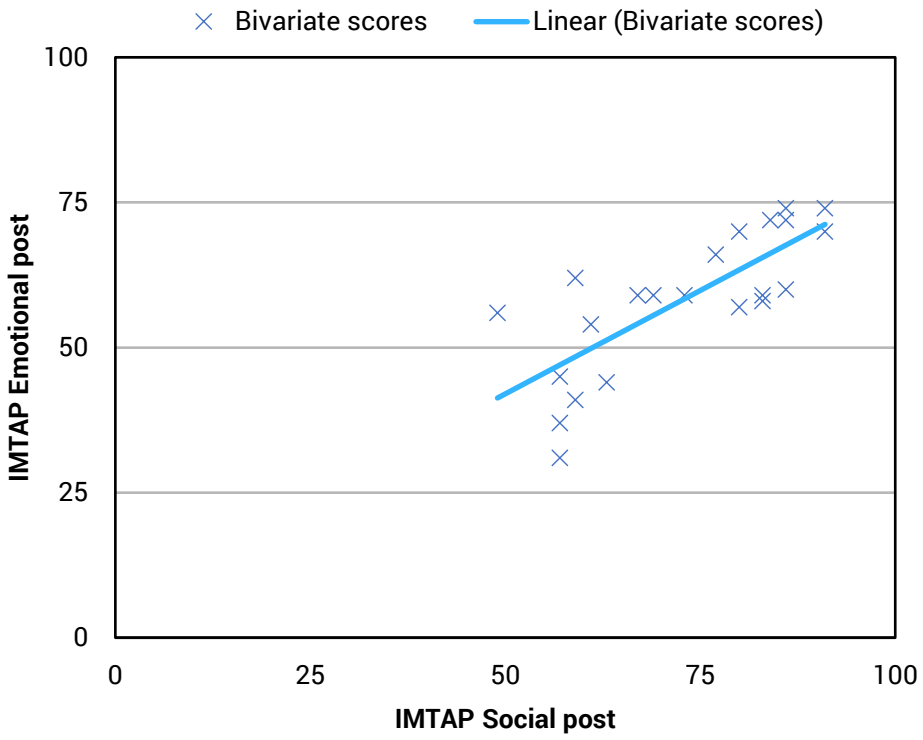

Figure 1: Scatterplot IMTAP emotional post vs. social post

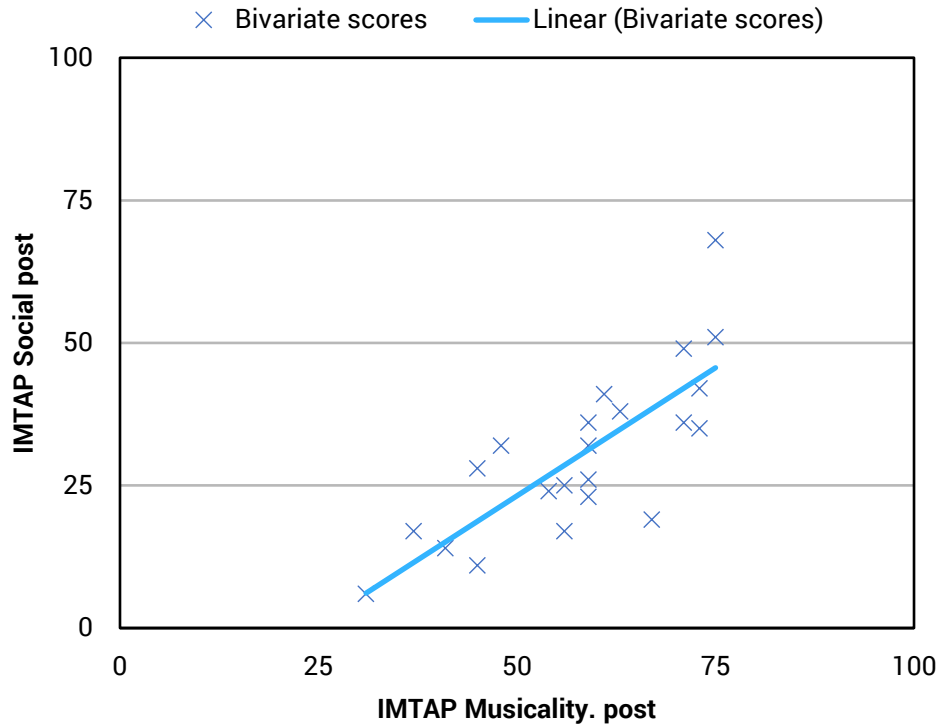

Figure 2: Scatterplot IMTAP social post vs. musicality post

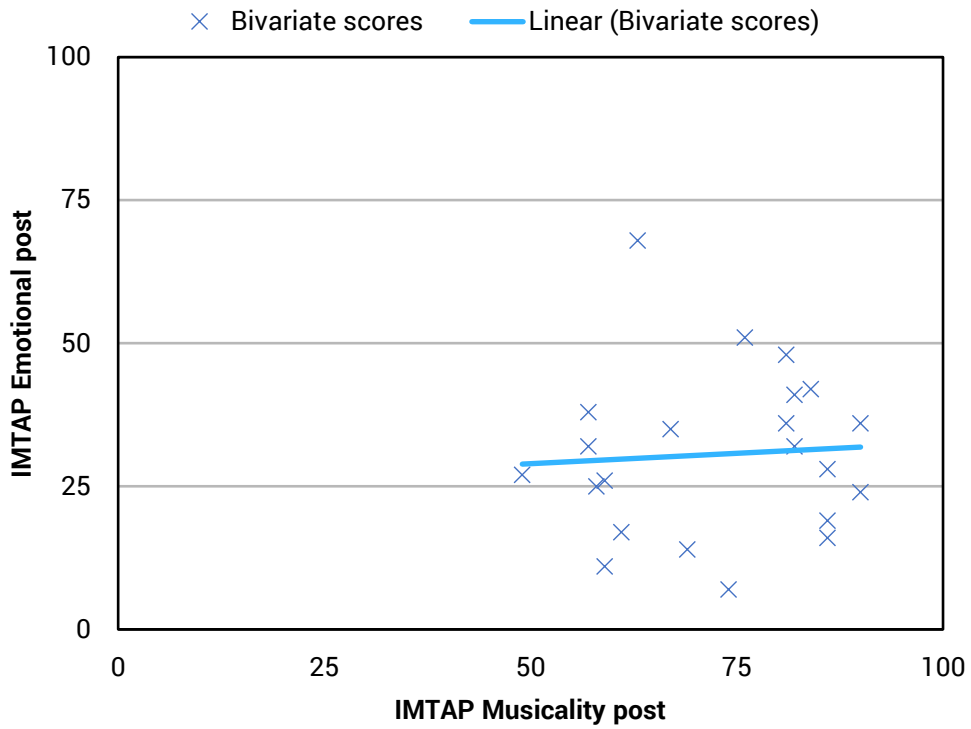

Figure 3: Scatterplot IMTAP emotional post vs. musicality post

Variable	Correlation	
IMTAP-E x IMTAP-S	R = 0.78	P = 0.000
IMTAP-E x IMTAP-M	R = 0.75	P = 0.000
IMTAP-M x IMTAP-S	R = 0.75	P = 0.000

Table 4: Bivariate correlation test

DISCUSSION

The research aim in this study was to monitor the impact of music therapy on the emotional and social functioning of Palestinian refugee children from Lebanon aged 7-11. The statistical analysis shows a generalised improvement from pre- to post- evaluations in the assessment measures used, with scores shown to be largely reliable in terms of probability. The music therapy intervention is therefore considered to have had a significant positive effect on the children's emotional and social functioning – a consideration supported by the thematic analysis of the qualitative data. The analyses of both the statistical and the narrative data indicate that music therapy may be useful for children living in comparable situations. The statistical data provide measurable outcomes representing diverse viewpoints: CGAS and VAS reflect a general clinical point of view; IMTAP provides an evaluation specifically focused on musical, affective, and social behaviour and capacities; whilst CBCL contributes a complementary and important viewpoint, that of the parents.

The narrative data provides descriptive evidence of the characteristics of this situation, illustrating how the children's quality of life is heavily compromised by adverse experiences including

dysfunctional home environments and abuse of various kinds, and describing presenting signs and symptoms in the children, such as lack of self-esteem, fear, social withdrawal, speech, learning and behavioural difficulties. This narrative data also complements the statistical data by documenting some of the tangible "flesh and blood" work involved in generating the evaluation measures. In accordance with the quantitative analysis, the thematic analysis of the case studies reveals themes relevant to the hypothesis of the research, that "music therapy is an effective therapeutic method in lowering anxiety levels in children suffering from the effects of stress and trauma, and in strengthening their self-esteem and sense of agency, thus contributing to the development of their resilience." The development of self-esteem and agency emerges clearly in the clinical stories of P and O. In the case of N, the child's improved confidence and emotional serenity contributed to the prospect of returning to his abandoned school career, clearly an indication of increased resilience. T's story, on the other hand, is important in reminding us that therapeutic interventions are always contextualised within each child's specific individual environment, inviting reflection as to the impact of this factor on effectiveness of treatment.

Both objectives of the research were achieved, the first of which (to test the hypothesis through the collection and analysis of controlled, standardised data and narrative data), has been discussed above. The consequences of the second objective (to develop and consolidate the clinical experience,

in music therapy intervention to date, with Palestinian refugee children in Lebanon) are evident in Assumoud's continued use of music therapy for children suffering from symptoms of toxic stress, and in the extension of clinical practice to include children of other ages and with different difficulties, with the definition of new research projects. One example is a research project for which data collection occurred in 2019, to monitor the effectiveness of music therapy for children aged between two and three years presenting with speech delay, in order to improve their communication skills.

Using music therapy as an intervention method with refugee children living under highly stressful socio-economic and emotional situations is pioneering work in Lebanon. Given the lack of similar studies, the parents' consent to their children's involvement in the research, their cooperation in the CBCL data collection, and the children's availability to try this innovative approach are all encouraging factors for further 'evidence-based' studies. Music therapy could be a useful therapeutic tool to deal with emotional distress in children. However, the case studies suggest that full achievement of clinical objectives and maintenance of the positive effects of treatment depend on the sustainability of support for children and their families, as the analysis of narrative data has illustrated. This might suggest that music therapy treatment cycles should be of longer duration, or that complementary therapies, such as psychotherapy, are available for continuation of clinical support. In the case of this study's context, Assumoud's mental health environments in the Family Guidance Clinics can potentially offer these possibilities; they are however sadly limited by the scarcity of both human and economic resources, which are subject to the same adversities as the community they serve.

LIMITATIONS AND REFLECTIONS

Several context-specific challenges necessarily shaped both the design and the conduct of this study. It was decided for ethical reasons that there would be no control group, and this clearly has implications for the external validity of the outcomes. Fewer children were worked with than originally

planned, again with implications for the outcomes.

Music therapy remains rare in Lebanon and the Arab countries, with relatively few trained therapists, and is even less proportionately available to children of refugee backgrounds. Unsurprisingly, therefore, there are few research projects examining its usefulness or effectiveness in such contexts: undertaking such research means addressing difficulties inherent to the context itself. Given the consequent limitations outlined above, it is clear that the "scientific" validity of such research may be questioned. However, from a humanistic standpoint which recognises the significance of social responsibility in the development of appropriate and adequate mental health resources for all peoples of the world, there would seem to be a role for evidence-based clinical research, however "humble," in monitoring, assessing and refining interventions. This has to be done sensitively, using not only appropriate standardised measures but also narrative accounts. We hope that this study has provided an example of negotiating specific obstacles to produce findings that are both locally useful and more widely interesting.

ACKNOWLEDGEMENTS

In representation of the lead partners of "Music and Resilience," Assumoud and Prima Materia, we would like to thank: "Ta'awon" Welfare Association Lebanon for the financial support for this research; the IMTAP evaluation team of music therapists, Alberto Balducci, Marco Lolli and Alessandra Meneghello; the Nordoff-Robbins Music Therapy Centre, London, for supporting and carrying out the statistical analysis; the Palestinian refugee families who agreed to their children's participation; most importantly, the children themselves, from whom we never stop learning.

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Ελληνική περίληψη | Greek abstract

Η μουσικοθεραπεία ως στρατηγική προστασίας απέναντι στο τοξικό στρες των Παλαιστινίων παιδιών προσφύγων στο Λίβανο: Μία πιλοτική ερευνητική μελέτη

Deborah Parker | Liliane Younces | Mohamad Orabi | Simon Procter | Milena Paulini

ΠΕΡΙΛΗΨΗ

Αυτό το άρθρο παρουσιάζει μία πιλοτική έρευνα μικτών μεθόδων για την αξιολόγηση του αντίκτυπου της μουσικοθεραπείας στη συναισθηματική και κοινωνική λειτουργικότητα Παλαιστινίων παιδιών προσφύγων στο Λίβανο, ηλικίας από 7 έως 11 ετών. Ο ερευνητικός στόχος ήταν να επιβεβαιωθεί η υπόθεση ότι η μουσικοθεραπεία αποτελεί μία αποτελεσματική θεραπευτική μέθοδο για τη μείωση του άγχους σε παιδιά που πάσχουν από τις επιπτώσεις του στρες και του τραύματος, καθώς και για την ενίσχυση της αυτοεκτίμησης και της αίσθησης της αυτενέργειας, ώστε να συμβάλλει στην ανάπτυξη της ψυχικής τους ανθεκτικότητας. Αναλύονται τα συγκεκριμένα γεωπολιτικά και κοινωνικά πλαίσια, σε συνδυασμό με παρόμοιες μελέτες, και περιγράφονται οι στρατηγικές συλλογής δεδομένων. Αφηγηματικά δεδομένα μουσικοθεραπευτών αναλύονται θεματικά, συμπληρώνοντας την ανάλυση των στατιστικών δεδομένων που συγκεντρώθηκαν από σταθμισμένα εργαλεία κλινικής αξιολόγησης. Καταδεικνύοντας το θετικό αντίκτυπο της μουσικοθεραπείας στη συναισθηματική και κοινωνική λειτουργικότητα, τα ευρήματα συζητούνται στο πλαίσιο ενός ευρύτερου αναστοχασμού για πιθανές εξελίξεις στο μέλλον.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

κλινική μουσικοθεραπεία, παιδιά πρόσφυγες από την Παλαιστίνη, τοξικό στρες, περιγραφή σειράς περιστατικών

Approaches: An Interdisciplinary Journal of Music Therapy
15 (1) 2023

ISSN: 2459-3338 | www.approaches.gr

ARTICLE

Can music therapy and community music co-exist in a community-based music service? A qualitative inquiry into reflections and perceptions from professionals in the field

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ABSTRACT

This study contributes to the current discourse on music for health and wellbeing by exploring how music therapy and community music are delivered within a community-based music service. The paper takes Moss' (2016) continuum of music and health practice as a starting point, aiming to illuminate the benefits and issues involved in integrating music therapy and community music within one community music programme. This qualitative study used semi-structured interviews with three participants (a music therapist, a community musician, and a dual practitioner), all practicing in various community contexts in Ireland. Van Manen's (1990) hermeneutic phenomenology method was followed for the analysis of the data. Findings suggest recurring themes, which resonate with the existing literature. These include: a disparity in awareness and perception regarding the role of the two professions; a need for clear professional identity and roles for various music and health professionals; and an enhanced understanding of boundaries with regard to working territory. Despite this, there is a desire for increased collaboration between the two professions and potential to design a pathway between the distinct expertise of music therapy, community music and indeed music education, to meet the needs of service users in community music education services. Recommendations are made regarding collaboration and parallel working to better meet the needs of service users. A gatekeeper is important to manage referrals and communication is needed to ensure service users gain the appropriate intervention at the right time. This paper offers reflection and practical solutions to enhance practice in community contexts.

KEYWORDS

music therapy,
community music

Publication history:
Submitted 23 Jul 2020
Accepted 23 Feb 2021
First published 14 April 2021

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BACKGROUND

The evolution of music therapy practice is based on both the vision of music therapy pioneers and conditions created by contemporary society. Music therapy has developed differently in each nation where it is practised. As music therapy becomes professionalised it develops in new and perhaps more socially engaged directions (Bunt & Stige, 2014). Currently in the Republic of Ireland, music therapy is still awaiting statutory recognition but, despite this, is widely being employed by many clinical facilities, hospitals, schools, and charitable organisations as a valued resource. Music therapists practise under the umbrella of The Irish Association of Creative Arts Therapists (IACAT).

This research began in response to several music therapists being employed by Music Generation which is Ireland's National Music Education Programme. Music Generation's stated aim is to transform the lives of children and young people through access to high quality performance music education in their locality. Skilled professional music educators are employed, across all musical genres and styles, to bring music education in many guises to the nation's children. Music Generation is co-funded by Music Network and philanthropic funding including U2 and the Ireland Funds and is delivered through local education programmes. Its emphasis is on music education for all. Many community musicians work in this organisation, as their approach to music education, creative learning and co-creation fit easily with the organisation's vision. In response to the needs of children and young people with intellectual disability, complex physical and mental health issues, Music Generation has employed music therapists to work in some of its regions (Music Generation, 2020).

The researchers in this study wished to explore how music therapists work alongside community musicians in this model and to reflect on benefits and recommendations for future working. Whilst this is not a new area of practice in some jurisdictions, it is in Ireland. The research aims for this study were:

- To explore how music therapists can integrate effectively into existing community music services
- To explore the issues and strengths of a service which combines both approaches alongside each other

This paper begins with definitions of music therapy, community music, music and health, and community music therapy before presenting the method and results of this study.

DEFINITIONS

Music therapy

For the purposes of this paper music therapy is defined as "a systematic process of intervention wherein the therapist helps the client to promote health, using music experiences and the relationships

that develop through them as dynamic forces of change" (Bruscia, 2014, p. xxii). The goal of therapy is to promote health and well-being. A proposed definition of health here "is the process of reaching one's fullest potential for individual and ecological wholeness" (Bruscia, 2014, p. xxiv).

Community music

Developed in the early 20th century, around the same time as music therapy, a parallel Western tradition of working with people musically was underway, defined as community music (Ansdell, 2002). Higgins (2003) defines community music as "an intentional intervention, involving skilled music leaders, who facilitate group music-making experiences in environments that do not have set curricula" (p. 5). Here, there is an emphasis on people, participation, context, equality of opportunity, and diversity. Musicians who work in this way seek to create relevant and accessible music-making experiences that integrate activities such as listening, improvising, musical invention, and performing.

As part of a funded research network, involving the Arts and Humanities Research Council, Rimmer (2015) discusses ways in which to improve the understanding of the current, historic and potential roles that community music can play in promoting community engagement. Central to the development of community music is a philosophy of empowerment. The profession is extremely well developed and has explored its relationship with Community Music Therapy in several recent publications (Bartlett & Higgins, 2018).

Music and health: Meeting at the edges of music therapy and community music

In her publication *Arts in Health,* Fancourt (2017) posits that the use of arts in health has recently blossomed as an area with a vast capacity for having a positive impact on individuals and societies. It is by nature an inherently inter-disciplinary field. It is an area that can provide a framework for its many varying practitioners to share their previous knowledge, and offer opportunities to contextualise new information. As research and practice are fundamental to the growth of any particular area, their close relationship and continued interaction is key to identifying clear healthcare needs, designing, testing and honing effective interventions and successful programmes that can be rolled out to benefit more people. "It is through this close relationship that the worlds of arts and health will bring the most to one another and provide the greatest value to individuals and societies globally" (Fancourt, 2017, p. xi). The recent World Health Organisation report provides significant evidence of the benefit of arts and health. Notably the evidence for music therapy is more significant and populous than any other arts approach (Fancourt & Finn, 2019).

Moss (2016) proposes a paradigm shift, one that would benefit policy makers, service providers, service users and practitioners by engaging with the arts in the many forms and approaches taken that can assist in improving health and well-being. Here the focus is on the skills of different practitioners and being open to a variety of approaches that help improve health and wellbeing. Bonde (2011) points out that some orientation tools are needed "as the field of music, culture and health is rapidly growing and becoming potentially confusing" (p. 113). Moss (2016) explains that, within her proposed theory, there is equality amongst all approaches to arts in healthcare (see Figure 1).

This paradigm aims to counter the artificial and defensive barriers constructed between practitioners and professional groups within the field, encourages greater respect and understanding between practitioners and assists in identifying training and development needs for the various arts professionals working in contexts related to health and well-being.

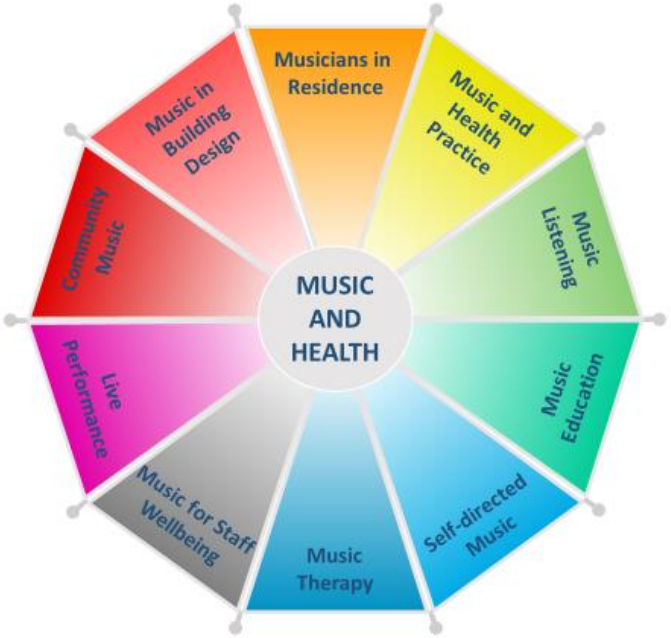

Figure 1: Music and health (Moss, 2016)

Moss' continuum of practice indicates that all approaches are equally important and valuable, but that distinct skill sets are required for each, as indicated in Figure 2.

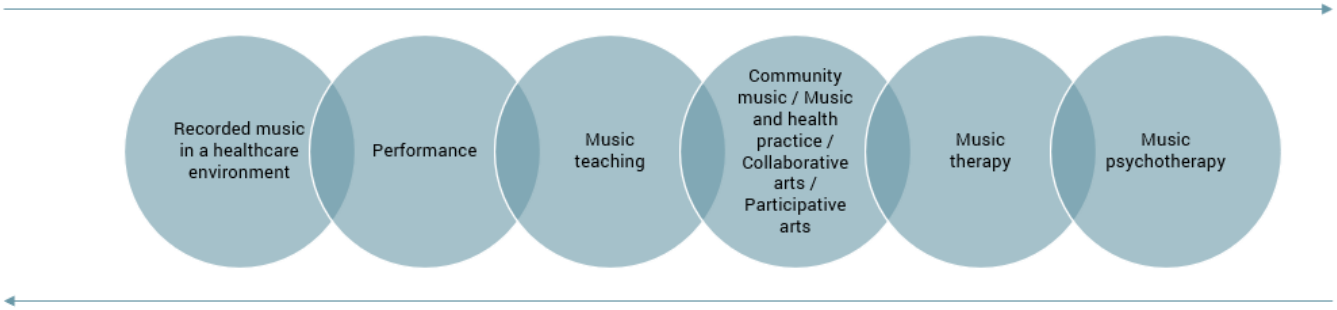

Figure 2: Music and health: A continuum of practice (Moss, 2016)

Community music therapy

Community music therapy can be considered as "a range of related ways of working, relative to each community" (Stige, 2012, p. 17). According to Stige et al. (2010), community music therapy has taken into consideration theories from fields such as systems theory, sociology, anthropology, and community psychology. Ghetti (2016) points out that music therapists have taken their practices from the more conventional private treatment setting, and placed these into communities to help promote

health and social change through active engagement. Stige et al. (2017) characterise community music therapy as collaborative and context-sensitive music-making, which focuses on giving voice to those who are disadvantaged in each context. It also relates to matters pertaining to human development, health, and equity. Community music therapy therefore involves what is called health musicing (Stige, 2002) as it focuses on the relationships between individual experiences and the possible creation of musical community (Ansdell & Pavlicevic, 2004). Ansdell (2002) points to the development in the 20th century of the two parallel professions of community music and music therapy and discusses their recent convergence into a similar landscape, suggesting possibilities of mutual accommodation in the future. Comprehensive overviews of community music therapy are explored in several seminal publications (Ansdell & Pavlicevic, 2004; O'Grady, 2012; Stige, 2012; Wood, 2016).

Despite the development of community music therapy, there is still often a division between the two professions of community music and music therapy in Ireland. These divisions concern resourcing, working territory, theoretical maps, and institutional legitimacy. There is relatively little contact in Ireland *between* the two professions, a surprising fact given their basic affinity (Ansdell, 2002), however some countries have developed strong working alliances, for example USA, Australia, and UK to name a few. Nonetheless, funding is often stretched between approaches with professionals vying for similar funding streams. In order for collaboration to take place, there needs to be mutual awareness and respect between the two professions (Moss, 2016; Tsiris, 2014). Murphy (2018) highlights that while there is a broad recognition of the overlap between music therapy and community music, there is a mixture of sympathy and suspicion in relation to each other's professions, with several of the music therapists interviewed admitting that they did not feel confident that they really understood community music. Murphy also interestingly pointed out that since in Ireland both of these groups study at the University of Limerick, it could offer a landscape for the cross dissemination of information.

It is possible that professions are getting too hung up on what Ansdell (2005) calls *definition anxiety*, thus becoming preoccupied with the identity and importance of their profession, as opposed to moving towards a more collaborative approach where working side by side for the betterment of society is the ultimate goal. We should be alert to shifts in societal needs, question the possibility of what music therapy can bring to our communities, and be willing to explore collaboration through the arts-based professions. Although the term collaboration appears frequently in music therapy literature, the concept as a process remains underarticulated and relatively unexplored (Bolger et al., 2018). This highlights a paucity in the literature. This paper arose from this gap in the literature, namely how can music therapy and community music co-exist in a community-based music service?

METHODOLOGY

The aim of the research was to gain first-hand knowledge from practicing music therapists and community musicians working within a community music education service, with the hope that this information may help further integrate the music therapy profession into community arts services. Given the nature of the study, a phenomenological qualitative approach was chosen. Phenomenology is a methodology used to describe lived experience. Van Manen's (1990) hermeneutic phenomenology was chosen as it is commonly used in health sciences research and acknowledges that one always

holds prior knowledge of a subject and proposes that there is no such thing as uninterrupted or uninterpreted data. The six steps of this qualitative approach are: (1) Turning to a phenomenon which seriously interests you and you want to study; (2) Investigating experience as it is lived rather than as it is conceptualised; (3) Reflecting on the essential themes which characterise the phenomenon; (4) Describing the phenomenon through the art of writing and re-writing; (5) Maintaining a strong orientation to the original question; and (6) Balancing the research question by identifying parts and the whole.

Purposive sampling was used to identify suitable study participants. Those chosen were selected from a list of potential community musicians and music therapists working within Music Generation and were practitioners who were engaged in teaching and research at the University of Limerick where the researchers were based. Researcher 1 (Joyce) conducted interviews and was unknown to the participants to increase impartiality in collecting data. Information about the project was sent to potential participants with 14 days given to consider whether they wished to participate. Informed consent was then given. This process ensured that participants chose freely to participate. Inclusion criteria were as follows: a) participants must have significant experience of working within a community arts service; b) be a qualified music therapist, or an experienced, trained community musician. It was hoped that, by including participants from both professions, this would offer an opportunity to explore the commonalities, resistances and possible biases encountered by both professions while working at a community arts service.

Semi-structured interviews were conducted with three participants: one music therapist; one community musician; and one dual practitioner (community musician and music therapist). The field of both community music and music therapy in Ireland is small and this study aimed to capture the lived experience of a small number of practitioners. All three practitioners live and work in Ireland, with a minimum of five years' experience in their respective professional field. Whilst being known to each other they did not work together. Two were female and one was male. The dual practitioner was selected as their experience was believed to be particularly rich, given her understanding of both professional practices. The study was approved by the University of Limerick Ethics Committee. Informed consent was obtained from all participants and a list of questions was supplied prior to interview (see Appendix).

Interviews were recorded and transcribed, verbatim. They lasted for a duration of between 21 minutes to 27 minutes. All data was stored on a password protected computer, accessible only to the researchers. All interview transcripts were anonymised to maintain participant confidentiality.

Data analysis was an iterative process, reading transcripts several times and developing themes using Van Manen's (1990) approach to data analysis: (1) Open coding; (2) Creating initial themes; (3) Grouping these into units of relevant meaning; and (4) Presenting the emerging themes.

A daily reflective journal was also used by researcher 1 (Joyce) to help process the information emerging from each analysis of the data, and through the coding process the main themes and sub-themes were identified.

Trustworthiness of data analysis was ensured by a) having two researchers review data independently, develop themes and discuss results and b) each participant was sent a transcription of their interview and were given one week to respond with any necessary changes. No changes were made by the participants.

FINDINGS

In this section, the results of the data analysis will be presented and discussed. Four themes were identified: awareness, identity, boundaries, and collaboration (see Figure 3).

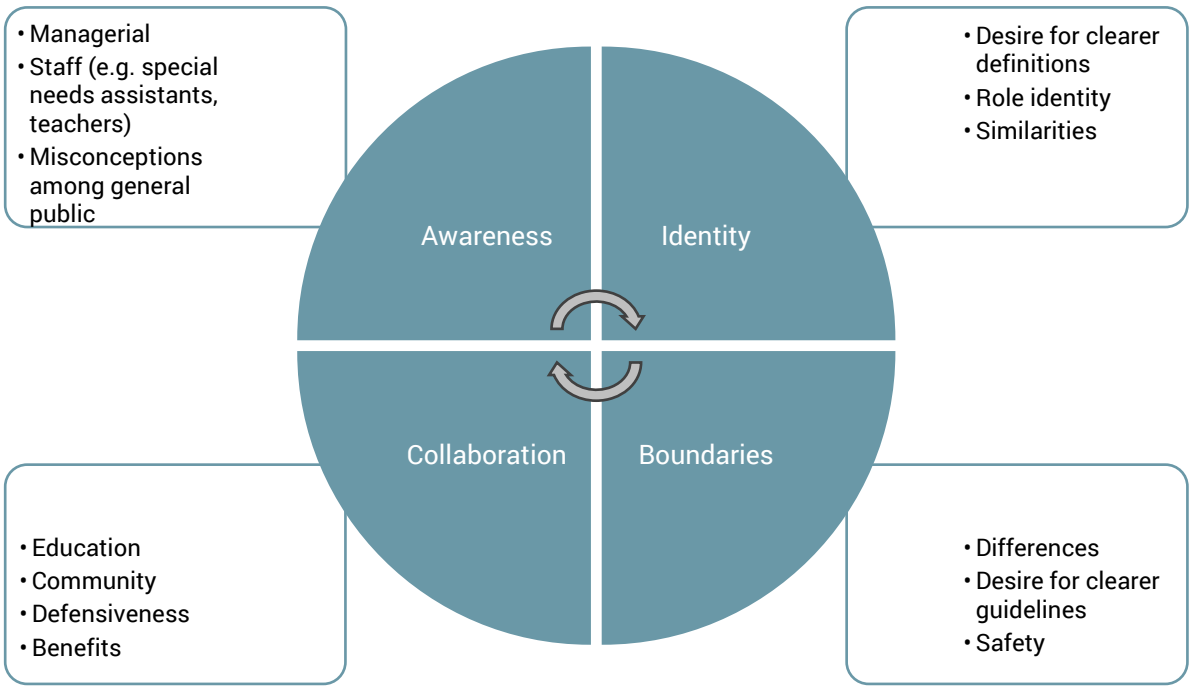

Figure 3: Themes and sub-themes

Awareness

A strong theme that emerged among all three interviews was the desire for a better awareness and understanding of each profession, namely community music and music therapy. This presented itself in many forms across all interviews and the general consensus was that there is a perceived confusion on a multitude of levels, from managerial to grass roots, as to the actual working descriptions of both professions in communities today. Both the community musician and music therapist expressed that their awareness and understanding of each other's professions "could be better." This point was particularly highlighted by the community musician who stated: "it even gets me agitated talking about it every time, because I don't have a clear concise understanding of… the differences and similarities." While the music therapist noted: "I wish I knew more about community musicians to really go into the nitty-gritty differences."

The music therapist also alluded to the fact that this confusion was also prevalent among the general public, as she stated: "I think any profession where there's confusion amongst the general public maybe as to what it is, can lead to a sort of defensiveness within the profession," a point which will be discussed further in the themes below. Although there now seems to be a growing awareness among the general public as to what music therapy can offer communities, there is still some

confusion surrounding it, as noted by all interviewees. The music therapist noted: "I think that it's moving in the right direction but very slowly." The community musician stated:

> …there are several occasions over the years that we've had to explicitly state that we're not music therapists. But somebody running a group that we're with would go, 'Yeah, but it's kind of music therapy?' But it isn't at all, and we're not music therapists, just to let you know that.

This was also noted by the dual practitioner on an occasion where a proposal for a music therapy programme was suggested by a friend to a nursing home manager:

> I have a friend who's a music therapist, I'm going to get her to do a proposal. And they said - 'Oh no, we do music therapy during the week'. And of course they don't do music therapy, they do some music during the week, be that community music or maybe it's just even playing music. So I think that awareness isn't always there and we have to keep, as music therapists, explaining often what the differences are.

A similar misconception was evident at two facilities providing services for people with disabilities. Again the dual practitioner was working with groups as a community musician, and had noticed that "people would often call it music therapy, so you have to be really careful of that too… I'm not sure if the awareness is really there with service managers and support workers."

Identity

The desire for clearer working definitions among one's own chosen profession was a theme that emerged, as the community musician stated that: "the hardest thing in community music, in terms of academia, is finding a definition of community music, there is none… you know, there's no kind of, well this IS what it is." The community musician also recognised the importance of clearer role identity as this can help the general public, care workers and other professionals in identifying each profession, because it was also noted by the community musician that: "…there's sometimes a misconception that community musicians offer the same thing as music therapists, and we know they don't. We just need to… find a clear way of explaining to people why we're not."

The dual practitioner also expressed similar experiences stating that:

> Community musicians I think walk the space between music therapists and music educators so they're kind of somewhere in the middle, they're working with like kind of similar groups maybe to music therapists. And I often think as well, like in my own work, my community music work, some of my sessions can look very similar to my music therapy sessions. And maybe if somebody was to come into the room, say a support worker and observe both, they mightn't be able to tell what the differences are.

With such similarities present, it can lead to uncertainty among staff and care workers, making it difficult to identify the role of a community musician or a music therapist within a service.

Boundaries

Further issues surrounding boundaries and resistance between the professions of community music and music therapy were encountered by all professionals. The dual practitioner stated: "I think things are changing a little bit but I do feel like before people were… possessive of their stance and their views on music therapy, and equally on community music. And there would be a resistance."

There were references within the interview to traditional music therapists wanting to be separate from community musicians as the dual practitioner informed the researcher: "Traditional music therapists would want to stay very far away from community music and be very separate." Instances of competitiveness also surfaced within the data when the dual practitioner expressed:

> Though there is kind of the politics around 'music therapists can do community music but community musicians can't do music therapy.' And I think that's kind of a key thing, and if you say that to community musicians that mightn't go down so well if you know what I mean?

The community musician was also aware of these defensive boundaries and stated: "that people have strong opinions in these areas… and do make assumptions and are presumptuous and do kind of disregard one over the other."

Though reflections on competition and defensiveness surfaced within the data, there was still a strong awareness that the two professions have much in common, as illustrated by the community musician:

> People say the only thing they have in common is music. But then with any kind of afterthoughts, I'm like - that's really not true, there is quite a lot in common. They can be quite similar pathways for different outputs, for different kind of ends and things like that.

This was echoed by the music therapist, who stated: "I would say that it is perhaps something that is getting better… I think we have to work with other professions, and we should be willing to work with other professions despite there being differences."

The issue of safe practice was also raised in terms of ensuring appropriate expectations of the work by clients. The community musician, for example, noted that clarity is needed that their work is not therapy. Their work in a mental health facility needed to be carefully curated to ensure no misunderstanding arose with clinicians.

Collaboration

Despite there being differences, resistance, and elements of perceived defensiveness between the professions, there are also clear indications of a desire for collaboration.

> *Community musician:* Music therapists have a lot to offer like the field of community music. And community music has a lot to offer the field of music therapy.
>
> *Interviewer:* Would lyric analysis be something that could be handed over to let's say a music therapist, to work towards the clinical goals perhaps?
>
> *Community musician:* Yeah, absolutely. You see that again, that's a perfect example actually. So that would be outside the community music remit so…we'd do the lyrics, inspire them and talk about them… we will be looking for kind of flags… especially working in that kind of work [prison setting]. But yeah, for lyrical analysis then you would absolutely pass on to a music therapist.

The dual practitioner, having a qualification in both community music and music therapy, shared valuable insight regarding this:

> …it would be amazing for music therapists and community musicians to get to collaborate all the time. The more musicians and people with an understanding of what's going on in the room, be that from a music therapy point or a community music point, like, the better. Community musicians can be so creative and have all these great ideas for activities. And then the music therapists have this unique way of framing what's happening and minding the space and kind of deepening the work as well. To have the two together…it'd be ideal.

The music therapist also experienced a similar desire for collaboration through her work as a music therapist at Music Generation specifically in terms of working with children with special needs:

> There is a little bit of nervousness that I found with some [community musicians]… and how to… work with children with special needs.
>
> But to have… a music therapist there, you know it breeds confidence…it adds a whole other layer so I think there's definitely room to learn from one another and collaborate with one another.

A similar scenario was evident in the interview with the community musician. When asked about collaboration and the possibility of referring a client to music therapy within the same service, the community musician stated:

> …if someone asked me of course …but I wouldn't presume to approach someone about music therapy for that kid… It's not my position to do that… I'm a community musician.

DISCUSSION

This research aimed to capture the opinion, through the lived experience, of three professionals working within their respective communities as music therapists and/or community musicians. It was hoped that the findings would help to illuminate the ongoing discourse in this developing area of practice, and thus help music therapy develop its 'pathway' (Aigen, 1998) among the creative arts services within communities. By conducting semi-structured interviews and analysing the rich and reflective content, the researchers extracted four main themes from the data, which resonated with the existing literature. This research suggests that community musicians and music therapists can co-exist effectively. This contributes to literature demonstrating the benefits of mutual respect and diversity of practice in terms of meeting client needs in varied contexts.

The findings suggest there is a growing awareness in Irish society as to the potential of music therapy, and therapists are now starting to find employment in more and more community-based services, such as Music Generation. Ruud (2004) suggests that music therapy should move out of its relatively marginal position in clinics and medical facilities in order to engage more directly with the problems and possibilities of music and health in societies. There is evidence that there are pioneering visionaries at managerial level in various Music Generation services around the country, who share that same ambition, as noted by the music therapist who stated: "I encountered a very on-the-ball kind of a director, just kinda knew exactly what she was talking about… and was very keen to get a music therapist on board."

Bruscia (2014) suggests that continued discussion and debate is required as changes occur in areas and settings of professional practice. The findings of the current study suggest there is also a desire among professionals to have an improved knowledge of each other's profession, with both reporting frustrations surrounding lack of understanding. There seems to be an awareness that there are similarities and differences but no concrete explanation of either.

There is a clear need to establish a stable foundation of identity to better inform the public perception of each profession. As there are already a myriad of new therapies developing to suit societal needs, it can be confusing for the general public, service managers and care workers to decide which therapy may be the most appropriate for their needs. This finding correlates with Bonde (2011) who pointed out that some orientation tools are needed as the field of music, culture and health is rapidly growing and becoming potentially confusing. In this context, identity plays a crucial role as an orientation tool, as it is clear from the interviews there are still misconceptions surrounding the identity of both community music and music therapy. Using music for health purposes is a relatively new phenomenon in this country, and any profession practicing without a strong identity can lead to confusion among the general population as to how to recognise it in practice. This resonates with Bunt and Stige (2014) who reflected upon the need for clearer definitions of roles and experiences between community musicians, music therapists and musicians performing in hospitals.

The research also revealed the existence of professional boundaries between community music and music therapy. There is an element of defensiveness over professional working territory, with both the community musician and dual practitioner expressing that lines can be crossed and boundaries blurred. Despite the availability of training at master's level, it is not a requirement in Ireland to have an official qualification to become a community musician and music therapy is unregulated in Ireland

currently. This can lead to defensive barriers as people can practice without adequate training. This finding would appear to resonate with that of Atkinson (2001, as cited in Ansdell, 2002) who suggests that music therapy is a tightly organised profession seeking to define its practice, whereas community music seems to be avoiding any such move in some quarters.

Ansdell (2002) discusses the development of community music and music therapy, and how there was an initial divergence but more recently a convergence into a similar landscape, which might suggest possibility of mutual accommodation in the future. Findings from the research would suggest that interviewees desire further collaboration and mutual understanding, and the potential benefits of such collaboration warrants further research.

Limitations include a small sample size, which reduces the generalisability of the findings as well as a lack of geographical or national spread. In both of these instances a larger sample size would be beneficial to gain a broader understanding of perspectives. Future studies may also benefit from including the viewpoint of managerial and service users of community arts services as their lived experiences are also central to this discourse.

CONCLUSION

The aim of this study was to gain insight into the lived experience of practitioners of community music and music therapy currently working in a community context in Ireland. The conscious decision to integrate extensive dialogue from the interview transcripts was indicative of the researchers' belief that the voice of the lived experience should remain at the centre of the debate, to allow practitioners to paint a true reflection of the current issues facing the professions pathway to development. This study is by no means a comprehensive review, but an interpretation of content to reflect and gain perspective within the current discourse. It is hoped that this data will help illuminate the pathways of future, more comprehensive studies in this ever-evolving area.

As disciplined practitioners of music therapy we are encouraged to embrace our responsibility as members of our societies and continue to ask the critical questions of how our profession can best serve our communities (Bunt & Stige, 2014). Further research regarding the role of music therapy and community music in community music settings is recommended. An interesting point was made by the community musician after the official interview had ended, and he reflected upon the importance of being involved in the interview process. He noted that he "was encouraged to think differently because of the questions, it's not something that I might just sit down and think about while I'm waiting for a session to start."

The themes highlighted in this study represent that of a profession that is still striving for recognition and a more definitive identity in Ireland. Ireland as a nation has known its own struggles with identity, and its senior citizens were raised in an environment of struggle, oppression, boundaries, and borders. Those same senior citizens in their younger years may not have ever imagined a time of peace, freedom and a land without borders or boundaries. But time and pioneering vision have afforded us the current landscape in which we stand proud, in our many shapes and interpretations of life, under our national flag. Ansdell (2002) spoke of an ever-increasing number of ways in which music therapy is currently being practiced, and posed the question as to which flag music therapists pin their colours to and sail under. He suggests there is an 'identity anxiety' among the professions of community music

and music therapy and recommends putting our energies into the betterment and well-being of our societies rather than focusing overly on professional issues. Nonetheless, this research presents a current example of how community music and music therapy are working alongside one another and it may be important to facilitate pauses in delivery to consider professional approaches from time to time. Presently, the profession of music therapy does not have statutory recognition from the Irish state, so perhaps an undercurrent of identity anxiety will remain in conversations until such time as the profession can stand proudly under its own flag of professional identity. Education and collaboration remain key components in disseminating knowledge of the possibilities of the profession, and realising its purpose of promoting health and well-being in societies. Procter (2001) suggests that music therapists must participate fully in their own communities if they are to assist people to live life to the full. This research concludes that music therapists need to be willing to explore what happens at the edges of the profession, particularly in the messy area of overlapping practice with other music practitioners, in order to ensure that their practice remains relevant and useful to the clients they serve.

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APPENDIX: INTERVIEW QUESTIONS

1. As an experienced music therapist / community musician, how would you describe your profession?
2. Would you feel comfortable enough to offer a description of music therapy / community Musician?
3. In Ireland, do you consider there to be a healthy awareness and understanding between the professions of music therapy and community music?
4. What would you consider to be the areas of resistance / commonalities / differences between the professions?
5. Would you feel comfortable collaborating with a music therapist / community musician?
6. Given that Ireland is an island nation which prides itself on community, do you feel there is currently a shift towards offering alternative approaches to health and well- being within communities?

Ελληνική περίληψη | Greek abstract

Μπορούν η μουσικοθεραπεία και η κοινοτική μουσική να συνυπάρξουν σε μία κοινοτικά βασισμένη υπηρεσία μουσικής; Μία ποιοτική διερεύνηση των αναστοχασμών και αντιλήψεων επαγγελματιών στο πεδίο

Fabian Joyce | Hilary Moss

ΠΕΡΙΛΗΨΗ

Αυτή η μελέτη συμβάλλει στον τρέχοντα επιστημονικό διάλογο σχετικά με το ρόλο της μουσικής στην υγεία και την ευεξία διερευνώντας το πώς η μουσικοθεραπεία και η κοινοτική μουσική παρέχονται εντός μίας κοινοτικά βασισμένης υπηρεσίας μουσικής. Με σημείο εκκίνησης το συνεχές της πρακτικής της μουσικής και της υγείας όπως έχει διατυπωθεί από την Moss (2016), το άρθρο επιχειρεί να διαφωτίσει τα οφέλη αλλά και τα ζητήματα που προκύπτουν από την ένταξη της μουσικοθεραπείας και της κοινοτικής μουσικής εντός ενός κοινοτικού μουσικού προγράμματος. Για την ποιοτική μελέτη πραγματοποιήθηκαν ημι-δομημένες συνεντεύξεις με τρεις συμμετέχοντες (έναν μουσικοθεραπευτή, έναν μουσικό στην κοινότητα και έναν επαγγελματία που συνδυάζει και τις δύο επαγγελματικές ταυτότητες), όλοι εκ των οποίων δραστηριοποιούνται σε ποικίλα κοινοτικά πλαίσια στην Ιρλανδία. Η ανάλυση των δεδομένων ακολούθησε την ερμηνευτική φαινομενολογική μεθοδολογία του Van Manen (1990). Τα ευρήματα καταδεικνύουν επαναλαμβανόμενα θέματα τα οποία συνάδουν με την υπάρχουσα βιβλιογραφία. Αυτά τα θέματα συμπεριλαμβάνουν την ανομοιότητα στην κατανόηση και αντίληψη του ρόλου των δύο επαγγελμάτων, την ανάγκη για ξεκάθαρες επαγγελματικές ταυτότητες και ρόλους για τους διάφορους επαγγελματίες στο χώρο της μουσικής και της υγείας, και μία επαυξημένη επίγνωση των ορίων που αφορούν στο εργασιακό πεδίο. Παρόλα αυτά, εκφράστηκε η επιθυμία για περαιτέρω συνεργασία ανάμεσα στα δύο επαγγέλματα και η δυνατότητα για σχεδιασμό μίας οδού που θα συνδυάζει τις ξεχωριστές εξειδικεύσεις της μουσικοθεραπείας, της κοινοτικής μουσικής, αλλά και της μουσικής εκπαίδευσης, με στόχο να ανταποκριθούν στις ανάγκες όσων

επωφελούνται από τις κοινοτικές μουσικές εκπαιδευτικές υπηρεσίες. Καταγράφονται προτάσεις για συνεργασία και παράλληλη εργασία με σκοπό την καλύτερη ανταπόκριση στις ανάγκες όσων χρησιμοποιούν αυτές τις υπηρεσίες. Ο ρόλος ενός θεματοφύλακα είναι σημαντικός για τη διαχείριση των παραπεμπτικών και απαιτείται επικοινωνία ώστε να διασφαλιστεί ότι οι συμμετέχοντες θα έχουν την κατάλληλη παρέμβαση και στο σωστό χρονικό διάστημα. Αυτό το άρθρο προσφέρει σκέψεις και πρακτικές λύσεις για τη βελτίωση της πρακτικής σε κοινοτικά πλαίσια.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

μουσικοθεραπεία, κοινοτική μουσική

Approaches: An Interdisciplinary Journal of Music Therapy
15 (1) 2023

ISSN: 2459-3338 | www.approaches.gr

ARTICLE

Integrative perspectives on mindfulness, music and music therapy: A literature review

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ABSTRACT

With increasing recognition of the advantage of working within a multidisciplinary team and interdisciplinary study for health, the incorporation of music and mindfulness across healthcare disciplines has become more common. The aim of this study was to explore the integrating theory and practice, key principles, and psychodynamic perspectives with respect to music therapy and mindfulness. Thirty articles were selected from electronic databases and grey literature. Conference abstracts and informal literature reviews were excluded. The articles were categorised and analysed according to methods, interventions, outcome measures and key messages. Key outcomes from the studies revealed that integrating mindfulness and music can enhance the musical experience, facilitate the music therapy process (e.g. Guided Imagery and Music), and contribute to mental wellness (e.g. stress reduction, emotional support, and self-awareness). Based on the data analysis, two core themes were identified: a) psychodynamic perspectives of mindfulness and music therapy; and b) here and now, letting go, nonself, nonattachment and being nonjudgmental. The link between music and mindfulness has been recognised during recent decades, and combining music and mindfulness demonstrated positive outcomes in the literature. The findings revealed several key perspectives and approaches between mindfulness-based practice (MBP) and music therapy. These findings can offer a new outlook to the therapeutic relationship and can give a practical and theoretical framework of combining mindfulness and music therapy.

KEYWORDS

music and mindfulness,
music,
music therapy,
mindfulness meditation

Publication history:
Submitted 24 Jul 2020
Accepted 14 Jun 2021
First published 19 Aug 2021

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INTRODUCTION

In the current healthcare environment, there is a growing interest in integrative health and mind-body-spirit (MBS) care. Mindfulness is a dynamic self-exploration process which pays attention to the body, feelings, mind, and mind objects with nonjudgmental awareness in each moment. It is an active state

of mind (Silananda, 2002) which originates in the four foundations of mindfulness principles that include: a) awareness of the body; b) awareness of feelings; c) awareness of mental phenomena; and d) awareness of truth and of the laws of experience (Goldstein & Kornfield, 2001). Mindfulness-based practice (MBP) is a self-empowerment practice which can create psychospiritual wellbeing and it is regarded as a potential treatment for improving health-related quality of life (Grossman et al., 2004; Kabat-Zinn, 2003).

Music has been used as a healing force throughout history (Choi et al., 2008; Ruud, 2008). Today, there is increasing recognition of the benefits of music for health and wellbeing and a great deal of work is conducted by various groups of healthcare practitioners (e.g. music therapists, psychotherapists, nurses, occupational therapists) under the umbrella of 'music in health' (Bunt & Stige, 2014; Edwards, 2016). MBP and music therapy can be viewed as types of integrative interventions or models of care which can bring the mind, body, emotions, and spirit into harmonious alignment as well as help manage stress and promote health (Hwang, 2018).

In therapeutic practices, integrating mindfulness practice is not a new concept and examples include MBP combined with art therapy or psychotherapy (Garland et al., 2007; Heaton & Crumpler, 2017; Monti et al., 2006; Soo et al., 2016; Witkiewitz et al., 2017). Indeed, MBP has been widely adopted across therapeutic disciplines and recently, combining mindfulness with music therapy has also been explored and its benefits have been discussed in the literature (Fidelibus, 2004; Van Dort, 2015; Van Dort & Grocke, 2013). However, the integration of MBP and music therapy is still young and marked by uncertainty; there is a need to explore the emerging literature related to these interventions. One of the aims of this paper, therefore, is to explore the extant research related to the integration of MBP and music and/or music therapy. Secondly, as a further analysis, the extant research related to MBP and music therapy in terms of psychodynamic perspectives and approaches will be investigated.

SUMMARY OF PREVIOUS REVIEWS OF MUSIC AND MINDFULNESS RESEARCH

With increasing recognition of the advantages of working within a multidisciplinary team and interdisciplinary study for health, healthcare practitioners are influenced to use a combination of new therapeutic tools, to work collaboratively, share their ideas and create a secure knowledge base for evidence-based practice (Carr & Wigram, 2009). For these reasons, resources for health and wellbeing such as mindfulness and music and their incorporation into healthcare practice have grown in popularity. Some studies have explored the clinical effects of mindfulness and music interventions used in combination with one another and with other therapies (Baer, 2003; Edwards, 2016; Hanh, 2008; Ji et al., 2017; Kabat-Zinn, 2009).

Music for health is continuously building bridges into healthcare services, and research has explored the use of music in various fields in order to achieve a diverse range of outcomes. Music for relaxation, often used in combination with meditation, has become an important feature of the potential range of complementary therapies used in clinical situations within the context of integrated healthcare and psychotherapy treatment (Witte & Dundes, 2001). Music interventions involving receptive methods and the link between meditation and music have also been explored (Chang et al., 2003; Fried, 1990; Grocke & Wigram, 2006; Lin et al., 2008; Scheufele, 2000; Thaut & Davis, 1993; Wolsko et al., 2004).

The technical Buddhist term for mindfulness (sati, 念), in the West, has been developed by Kabat-Zinn who helped to develop a culture of mindfulness in medicine. The word 'sati (in Pali) (念 in Chinese)' is comprised of two aspects, 'mind (心)' and 'in the present moment (今)'; it is defined as "the practice of maintaining a non-judgmental state of heightened or complete awareness of one's thoughts, emotions, or experiences on a moment-to-moment basis" (Merriam-Webster Online, 2018). A substantial body of research reveals that mindfulness can impact mental and psychological health in terms of reducing anxiety, depression and chronic unhappiness, changing negative emotions and thoughts to positive ones, and decreasing perceived stress. In earlier works and even still today, mindfulness is adapted to increase students' ability to concentrate in class and also for people who have experienced a scattered or unsettled mind to stay calm (Baer, 2003, 2015; Carlson et al., 2007; Kang et al., 2009; Krusche et al., 2012; Paul et al., 2007; Vøllestad et al., 2011; Winbush et al., 2007).

Recently, the link between music and/or music therapy and mindfulness has been recognised (Diaz, 2010, 2013; Eckhardt & Dinsmore, 2012; Innes et al., 2017; Lesiuk, 2015, 2016; Lin et al., 2008; Liu et al., 2019; Medcalf, 2017; Steyn, 2013; Tomaselli, 2014; Vidyarthi et al., 2012). Fidelibus (2004) mentioned that as therapists listen to their clients in the present musical moment, and then join in and start to play with their clients, the therapists are "in a seemingly unfettered state of mind, playing with a Zen-like, precise awareness" (p.174). The unfettered state of mind is often represented as a symbol of the Zen master's mind and it is also referred to as expanded and purified consciousness. Such states of mind can be cultivated by practising mindfulness and these states of consciousness can progress towards immovable wisdom (不動智), which is the desired result of mindfulness practice. The mind and soul can be stretched and expanded by new experience, self-knowledge, self-insight and self-transformation and the unfettered state of mind can be experienced through MBP and music therapy.

There are certain similarities in the purpose of MBP and music therapy, such as accessing expanded conscious states, achieving and strengthening the expanded ego, promoting total development of personality, and discovering the authentic self (Aldridge, 2003; Beck, 2005; Lipe, 2002; Sahn, 1997; Shapiro & Giber, 1978). Not only have these similar therapeutic aims increased the combined use of MBP and music therapy, but a growing interest in psychospiritual wellbeing has also accelerated the use of MBP and music therapy in the healthcare environment, both separately and in combination (Bazzano, 2011; Long et al., 2001; Tsiris, 2018; Valente & Marotta, 2005; Wlodarczyk, 2007). Several studies have focused on the combination of MBP and music therapy for cultivating self-awareness, self-development, self-transformation, and music performance (Goldberg & Dimiceli-Mitran, 2010; Van Dort, 2015).

For example, the possibilities for profound insights and spiritual transformation of Guided Imagery and Music (GIM)[1] and mindfulness meditation were introduced (Goldberg & Dimiceli-Mitran, 2010). They described mindfulness meditation as a way to permit people to observe one's inner mind

[1] Guided Imagery and Music (GIM) is a music-assisted therapy used to explore one's own inner world and helps clients to work on significant life issues. GIM is a form of psychodynamic therapy and incorporates music listening in a deeply relaxed state by a guide to evoke sensory and emotional responses and to stimulate imagery, memories and feelings in the listener (Bruscia & Grocke, 2002).

works and "GIM has elements of mindfulness in that it requires a sense of self-awareness in the moment during music listening and imaging" (Goldberg & Dimiceli-Mitran, 2010, p.1). Van Dort (2015) suggests that combining principles of mindfulness and the GIM process can enable the clients to explore self-awareness and self-understanding. She defines music-based mindfulness as: "the awareness that emerges through paying attention, on purpose and non-judgmentally, to responses evoked by specifically selected music in a therapeutic session" (Van Dort, 2015, p.222). Paying attention, nonjudgmental awareness, nonattachment and letting go are the essences of mindfulness (Lomas et al., 2017). In these ways, certain core principles of mindfulness can therefore be matched with music therapy, such as the GIM and the Music Imagery (MI) process.

Mindfulness approaches have begun to be explored in music therapy with various groups (e.g. music therapy trainees, music therapists, clients with Huntington's disease and substance addictions - drugs and alcohol dependencies) (Mika, 2011; Van Dort, 2015; Van Dort & Grocke, 2013). For example, the positive effects of mindfulness for music therapists who practise improvisational music therapy have also been reported (Fidelibus, 2004). Fidelibus (2004) explored the use of mindfulness (e.g. present moment/here and now experience) in music therapy clinical improvisation and investigated the music therapist's own experiences and perspectives when attending to the present improvisational musical moment. He reported that "therapists shifted focus between being in the moment-to-moment movement of the music, attending to their clients' moment-to-moment musical movements, and perceiving the overall musical interaction" (p.174). In addition, Fidelibus (2004) found that during the process of improvisational musical moments, the "therapist's attention hovered between a microscopic perspective to a macroscopic perspective" (p.174). Soho (1986) identified this macroscopic perspective as 'right mind' and explained that it is like water flowing everywhere freely, not like frozen ice which is unable to move and be used. The therapist's macroscopic perspective can be meaningful within the therapeutic relationship for a better understanding of the client's or the therapist's own mind, as well as contemplating the therapeutic process.

Besides therapeutic practice, there have also been promising contributions of mindfulness practice to music appreciation and performance. Rodríguez-Carvajal and de la Cruz (2014) found a boost in attention and concentration levels in audiences who followed the induction stage of mindfulness practice and that listening to, as well as performing music itself, can contribute to the induction of mindful states. They also reported that combining MBP with music can be beneficial in reducing music performance anxiety and stress. A mindfulness course has been set up for music students at the Guildhall School of Music and Drama in London. These examples illustrate how MBP can be adopted by musicians and the performing arts (British Association for Music Therapy, 2018).

The emerging themes from these reviews appear to demonstrate that integrating MBP and music and/or music therapy may have positive effects in various health care settings. Although several studies were conducted in recent years to explore their combined use, a systematic literature review on this has not been done. Secondly, previous reviewers have highlighted various aspects of integrating practices of MBP and music therapy, but there is a significant lack of discussion of the key common concepts, principles, psychodynamic perspectives, and philosophical approaches of combining MBP and music therapy. Therefore, exploring the potential shared core concepts,

therapeutic factors, and basic underlying principles between music/music therapy and MBP will be an important feature of this study. This may provide an appropriate theoretical framework for combining MBP and music and/or music therapy and will offer a combination of possibilities in order to both serve practitioners and personal development.

METHOD AND SAMPLE

To obtain a maximum number of studies, the keywords used in the literature search were: 'music', 'music therapy', 'mindfulness', 'mindfulness meditation' and 'mindfulness and music'. Literature was searched from the English language electronic databases to find peer-reviewed research papers (e.g. PubMed, MEDLINE, PsychInfo, CINAHL, Wiley Online Library, EMBASE, Cochrane Library and NICE Evidence) and grey literature was included such as dissertations. Exclusion criteria included conference abstracts and informal literature reviews.

After both electronic and manual searches, initially, 47 peer-reviewed articles and nine unpublished dissertations were identified. However, only 30 studies met the inclusion criteria, and 26 texts were excluded (e.g. no relevant studies and interventions, insufficient information). Therefore, a total of 30 studies were selected for review, although two studies by Diaz (2010, 2013) were based on the same study. Countries of the corresponding authors included the United States (19 studies), Australia (3 studies), United Kingdom (4 studies), Canada (1 study), Spain (1 study), South Africa (1 study) and New Zealand (1 study).

Initially, the articles were categorised according to specific methodology types which were qualitative, quantitative, mixed methods, and theoretical based studies. The studies were then analysed according to participant demographics; interventions; duration; methodology approaches; outcome measures; and findings (see Appendix for a summary of the reviewed articles).

RESULTS

Participants

Ages of participants ranged from adolescents to elders. The participants in the 30 studies were: a) music therapists (Fidelibus, 2004; Medcalf, 2017; Mika, 2011); b) undergraduate and graduate music students (Baird, 2016; Chang et al., 2003; Diaz, 2013; Farnsworth-Grodd, 2012; Lin et al., 2008; Steyn, 2013); c) music performers (De Felice, 2004; Khalsa et al., 2013; Langer et al., 2009); d) researchers (Brown, 2011); e) music therapists, meditation experts and medical practitioners (Hwang, 2018); and f) others: adult volunteer participants (Tomaselli, 2014; Vidyarthi et al., 2012), and a senior student (Robarts, 2009). Several studies describe the participants' diagnoses including: Huntington's disease (Grocke & Wigram, 2006); breast cancer (Lesiuk, 2015); Alzheimer's disease (Innes et al., 2017); drug and alcohol dependence (Van Dort & Grocke, 2013); autism spectrum disorder (Lau, 2011); and depression (Eckhardt & Dinsmore, 2012).

The remainder of the studies were literature-based research (Baer, 2003; Oyan, 2006; Rodríguez-Carvajal & de la Cruz, 2014; Xu, 2010). Sample sizes in the selected studies were varied, ranging from one (Robarts, 2009) to 203 participants (Langer et al., 2009). The target population of most studies were adults, and in only two papers it was children (Lau, 2011; Robarts, 2009). The studies conducted

sessions in groups, ranging from 4 to 143 participants. The remaining studies conducted individual sessions (Lau, 2011; Robarts, 2009).

Interventions

Various types of interventions were used to explore the integration of MBP and music (Table 1). Interventions can be divided into active and receptive MBP and music activities. The most common interventions were receptive approaches.

Mindfulness Meditation	Breathing techniques[R], Body scan[R], Eight weeks meditation training[R&A], Sitting meditation[R], Walking meditation[A], Eating meditation[A], Washing dishes meditation[A], "Be Here Now" practice[R&A]
Meditation	Zen meditation[R], Breathing techniques[R], Vipassana[R&A], Yoga[A]
Mindful music listening	Combining music listening and mindfulness practice[R&A], Live music listening (e.g. classical music)[R], Nylon-stringed guitar played[A], Attention music listening (e.g. 'Brahms's Symphony No. 1, Polonaise' from Christmas Eve by Rimsky-Korsakov; Victor Herbert's 'March of the Toys' from Babes in Toyland; and Nature sounds CDs (forest sounds from the series Echoes of Nature)[R]
Music therapy	Improvisation[R&A], Listening to music[R]
Others	Live music-accompanied body scan[R], Music performance[R&A], Music activities/Sound accompanied by mindfulness attitudes[R&A], Progressively control sound through their own respiration[R], Progressive muscle relaxation (PMR, shortened version)[R], Imagery[R], Mandala drawing or writing[R&A], Psychological Skills Training (PST)[R]

Table 1: Types of MBP and music [Notes: Active (A); Receptive (R); Receptive and Active (R&A)]

Duration

A specific duration time, session type (e.g. mindfulness and music combined or separately), and interview length were identified. In terms of mindful meditation, the duration of the session was between 30 minutes to one and a half hours. In the case of music intervention including musical performance, music listening and music therapy, the range of session times ranged from 15 minutes to 30 minutes. For example, 15 minutes of music listening and then 30 minutes of mindfulness practice. The length of the interview process was reported to have ranged from 30 minutes to 1 hour and daily home practice ranged from 4 to 12 weeks. Examples of home practice comprised of guided mindfulness audio files and music in mp3 format which were distributed via email for home practice. Most of the studies in the current sample were short-term, lasting around 4-12 weeks with weekly 15–90-minute sessions. However, the duration of the data collection and the data analysis of studies were not clearly reported in most studies.

Methodology approaches

Of the 30 studies, the numbers of different methods used were as follows: a) qualitative studies (*n* = 10); b) quantitative studies (*n* = 12); c) mixed-method studies (*n* = 1); and d) theoretical based studies (*n* = 7). Characteristics of studies were summarised according to methodology types which were qualitative, quantitative, mixed-method, and theoretical based studies (see Appendix).

Outcome measures

Each study used a different outcome measure and assessment. Depending on the methodology of the study, the type of outcome measure utilised varied. For qualitative approaches, observational ratings (eight studies), interviews (six studies), discussions (six studies) and combined qualitative observation with open-ended interviews were used as the primary forms of data collection. Likert-type scales (six studies) and paired t-tests (five studies) were frequently used as quantitative measurements. One study took a mixed approach (Langer et al., 2009) and it used a self-report questionnaire with a 10-point Likert scale and open-ended interviews. To examine the effect of mindfulness, four studies utilised systematic mindfulness scales such as the Five Facet Mindfulness Questionnaire (FFMQ) (Farnsworth-Grodd, 2012; Steyn, 2013), the Mindful Attention Awareness Scale (MAAS) (Langer et al., 2009; Tomaselli, 2014), and the Langer mindfulness scale (LMS) (Langer et al., 2009).

Seven studies used psychological wellbeing scales which were Ryff's Psychological Well-being Scale (Steyn, 2013), the State-Trait Anxiety Inventory (STAI) or State Anxiety Inventory (SAI) (Chang et al., 2003; Farnsworth-Grodd, 2012; Khalsa et al., 2013; Lin et al., 2008; Stern, 2012) and the Beck Anxiety Inventory (BAI) (Tomaselli, 2014). Three studies combined mindfulness scales (e.g. FFMQ, MAAS) with psychological wellbeing scales (e.g. STAI, BAI) (Farnsworth-Grodd, 2012; Steyn, 2013; Tomaselli, 2014). In order to assess music performance anxiety, four studies used a validated inventory such as the Kenny Music Performance Anxiety Inventory (K-MPAI) (Steyn, 2013) and the Performance Anxiety Inventory (PAI) (Chang et al., 2003; Farnsworth-Grodd, 2012; Lin et al., 2008). The rest of the outcome measures (e.g. journals of logs and memos, recorded videotapes, home practice logs, autobiographical accounts) can be found in the Appendix.

Key reported outcomes

Given the variety of unique outcome measures used, several key outcomes of integrating MBP and music and/or music therapy were identified in the selected studies.

Managing mental and emotional stress and improving clients' outcomes

Van Dort and Grocke (2013) introduced the effects of combining mindfulness sessions and music therapy (e.g. group music, imagery) for people who are living with drug and alcohol addictions. They reported, "there are rich, emotional, and personal experiences that have been a privilege to facilitate, and certainly demonstrate mindful awareness within the music and imagery process" (p.128). Not only are mindfulness and music helpful for drug and alcohol dependencies, but it may also be a useful

intervention for women receiving adjuvant chemotherapy for breast cancer (Lesiuk, 2016). For example, combining music listening and mindfulness exercises may have beneficial effects on women with breast cancer who experience concentration problems and mood distress. In terms of mood and distress, Eckhardt and Dinsmore (2012) found that mindful music listening could be a potential treatment for older adults who suffer from emotional difficulties such as depression.

Innes et al. (2017) testified that having a daily programme that includes meditation and music can significantly enhance both subjective memory function and objective cognitive performance in adults with Subjective Cognitive Decline (SCD), and they claimed that meditation and music may be promising for improving outcomes in stress, mood, sleep, and cognitive function in this population. These findings reveal that combining mindfulness and music can improve the client's outcomes, and these interventions are usefully adapted for people's health and wellbeing.

Mental attitude change and reducing music performance anxiety (MPA)

The link between mindfulness and performance anxiety has been explored (Baird, 2016; Chang et al., 2003; De Felice, 2004; Farnsworth-Grodd, 2012; Lin et al., 2008; Steyn, 2013; Tomaselli, 2014). Lin et al. (2008) believe that mindfulness meditation can have a significant impact on musical performance skills and a musician's mental health, which is supported by Baird (2016) and Farnsworth-Grodd (2012).

Baird (2016) found that there are positive mental shifts (e.g. increase in mindful awareness) in a musician regarding music performance and performance preparation. Farnsworth-Grodd (2012) investigated the relationship between music performance anxiety (MPA) and meditational practice in order to develop coping strategies (e.g. self-acceptance, self- love, positive emotions such as hope). This study reported that mindfulness-based intervention could reduce music performance anxiety.

Steyn (2013) argues that mindfulness could be an effective intervention to improve the psychological wellbeing of music students. She reports that psychological skills training (PST) and mindfulness, acceptance and commitment (MAC) protocol had a moderately significant impact on important psychological dimensions of undergraduate music students. Tomaselli (2014) demonstrated that there is a large decrease in anxiety scores, pre-to-post-test, when mindfulness practice is combined with music listening and this may be a strategy that musicians can adopt to manage stressful emotions, by listening to music or through playing their own instrument. Therefore, mindfulness meditation may be a useful tool for aiding musicians to combat the negative impact of music performance anxiety and bring about positive changes in mental attitude (e.g. self-acceptance, self-kindness).

Facilitating music therapy work

The positive effect of mindfulness on musical improvisation and music therapy work has been investigated (Diaz, 2010; Fidelibus, 2004; Lau, 2011; Medcalf, 2017; Mika, 2011). Fidelibus (2004, p. 271) mentions, "the integration of spiritual tenets into the practice of clinical music making opens possibilities, not solely to explain or better understand, but also as affirmation for the practitioner of music therapy." Mindfulness and music therapy might support one another, and mindfulness can be useful for music therapists (e.g. therapeutic attitude) as well as for emotional support to clients.

Mika (2011) found that music therapists can apply mindfulness to their clinical work and music therapists recognise the potential benefits of mindfulness as an effective intervention. Mika states that the majority of the respondents in the mindfulness group reported that without distraction, the task had changed their quality of listening by increasing their ability to concentrate on the music. In this way, studies revealed that mindfulness can be a promising intervention that could contribute valuable attributes to music therapy and other multidisciplinary health fields.

Enhances the musical experience

According to Brown (2011), there is a strong link between flow (optimal experiences) and focused attention (mindfulness). Flow can be defined as "the holistic sensation that people feel when they act with total involvement" (Csikszentmihalyi, 1975, p.36). In this state of flow, "people experience a narrow field of intense concentration, they forget about personal problems, feel competent and in control, experience a sense of harmony and union with their surroundings" (Wrigley & Emmerson, 2013, p. 293). He found that mindfulness could contribute to understanding the phenomenon of flow during collaborative music performances and there is a relationship between mindfulness and creative musical performance, music experience and aesthetic response.

Similarly, Baird (2016) states that meditation promises to have a significant impact on music experience and musical performance skills. After practicing meditation, participants reported positive changes in their mental and physical experiences related to MPA. Participants experienced mental distress before and during performances, therefore, mediation can allow them to be more focused in performances and feel better about the prospect of performing.

To conclude this section, the literature referred to, shows the value of meditational practice and music (combined or separately) within various settings. Several key outcomes were identified from the studies. The majority of the results revealed that integrating MBP and music therapy can contribute to mental wellbeing and improve client outcomes, facilitate music therapy work, reduce emotional distress and anxiety, enhance the musical experience and create positive attitudes by encouraging changes to thoughts and behaviours.

Emerging themes

The purpose of this study is to examine previous literature reviews and to explore the key principles and psychodynamic perspectives of integrating MBP and music therapy. Through the analysis of data, the following core themes were identified: a) psychodynamic perspectives of music therapy and mindfulness; and b) here and now, letting go, nonself, nonattachment and being nonjudgmental.

Psychodynamic perspectives of music therapy and mindfulness

> Transpersonal psychotherapy practices, especially the incorporation of meditation and the use of imagery, seem to be entering the mainstream. (Goldberg & Dimiceli-Mitran, 2010, p.1)

Several studies have shown preliminary evidence regarding the psychodynamic perspectives and approaches of combining MBP and music therapy (e.g. Brown, 2011). Mindfulness in its original form is practice for cultivating concentration (samādhi) and insight (vipassanā) in a monastery (Speca et al., 2000) but nowadays, MBP has been increasingly applied as a tool to promote self-awareness, self-regulation and self-transcendence in healthcare. It has been shown that MBP itself is growing and this is being reflected in therapeutic practice. It is beginning to be used in psychodynamic music therapy approaches such as GIM and MI (Van Dort & Grocke, 2013).

In music therapy, relaxation and meditation techniques are sometimes associated with the induction stages of GIM and MI. GIM is described as an in-depth experience in which specifically programmed classical music is used to generate a dynamic unfolding of inner experience (Goldberg, 1995). GIM is a unique journey of self-discovery, self-exploration and self-awareness (Bunt, 2010). A GIM session lasts between one and a half to two hours (the components of a GIM session are prelude - induction - music and imagery - postlude). It starts with the 'prelude' and before listening to music, there is an 'induction' which includes relaxation and concentration (Bonny, 2010). During the GIM process, a mindfulness approach to concentration can be adopted by focusing on the imagery, listening to music, drawing the imagery in a mandala as well as the induction process. Grocke and Wigram (2006) said "focusing or centering is a necessary part of the relaxation process where the therapeutic intention is for the mind to be quiet and still" (p.127). Besides the purpose of focusing, mindfulness can support the process of self-exploration in a unique way too. The feelings, memories and mind can be explored in response to the music and this can be integrated into the client's own self-understanding. Mindfulness could be a useful tool for exploring the mind and inner self.

In the GIM experience, various aspects of feelings, sensations, memories, and consciousness may arise in response to the music. In this process, images or personal meaningful symbols may dynamically appear. The types of imagery experiences were seen to be linked to the function of organs, objects and mind and these relations are briefly summarised in Table 2. Wigram et al. (2013) mentions that "images are stimulated in all sensory modes (visual, auditory, tactile, kinaesthetic, olfactory) as well as feelings, fantasies, memories, thoughts and physical sensations" (p.11).

In the context of meditation, firstly, the mind is defined as: a) the intellectual functioning of consciousness; b) the field of sense and sense-reaction; and c) the subjective aspect of consciousness (Bhadantachariya, 1971). Secondly, the mind is the state of consciousness and it has the ability to notice, and to be aware and to develop an understanding of phenomena (Sumanasara & Akira, 2006).

Thirdly, the function of the mind is explained by 'six sense doors' (eye, ear, nose, tongue, body and mind), 'six sense objects (visible form, sound, odour, taste, touch, and mental objects and phenomena)' and 'six aspects of consciousness' (seeing, hearing, smelling, tasting, touching and discriminating). The six aspects of consciousness are generated by the 'six sense doors' in relation to the 'six sense objects.' The primary purpose of mindfulness is 'purifying the six sense doors' and 'seeing things as they really are' (Goldstein, 2013; Kabat-Zinn, 2013). This can be achieved by mindful awareness and nonjudgmental attention to the experiences in the present moment. Through these deliberate efforts of mindfulness, the spiritual dimension can be expanded, and inner transformation can be achieved.

Organs	Objects	Mind	Types of imagery experiences (in response to music)
Six sense doors	Six sense objects	Six aspects of consciousness	Various forms and aspects of imagery experiences: • Pleasurable/unpleasable experiences and responses • Vividness and activity of the imagery • Time imaging, intensity of emotion experienced • Pure musical transference (fully engaged in the music) • Abstract imagery • Transpersonal experiences and imagery (peak and spiritual experiences) • Healing imagery
Eye	Visible form & colours	Seeing	Visual (Eye - Form - Seeing) • Scenes (e.g. scenes of nature, fragments of scenes), pictures • Colours, crystal, flash, bright, light, dark • Figures, archetypal figures (e.g. myths & heroes, great mother, father, child, God, wise old woman, figures from legendary stories) • People, animals • Shapes, symbolic shapes and images (e.g. tunnel, hole) • Spiritual symbols (e.g. mandala, cross, star)
Ear	Sound	Hearing	Auric (Ear - Sound - Hearing) • Sound, shout, tone, silence/quiet, dialogue • Musical sounds (e.g. melody, harmony, tempo) • Altered auditory experiences
Nose	Odour	Smelling	Olfactory (Nose - Odour - Smelling) • Smell, scent, odour, aroma
Tongue	Taste	Tasting	Gustatory (Tongue - Taste - Tasting) • Taste, sweet, sour, bitter, fresh, juicy
Body	Touch & texture	Touching	Sensory/ kinaesthetic sense and imagery/ body imagery (body-touch-touching) • Body sensations (e.g. feeling lighter, heavier, pain or floating, falling) • Body position and movements (e.g. hands creating a shape, sitting, lying, walking, running) • Somatic imagery (pain felt in the heart) • Feeling the softness, feeling cold and warm, grasp • Heaviness, pressure, painful feeling
Mind & reasoning & thought	Mental objects & phenomena	Knowing & discriminating	Feelings/ emotions/ memories/ thoughts/ noetic images/ intuitive sense of images/ intuition and insight (mind - mental objects - discriminating) • Feeling of scenes/ feeling of sound/ feeling of olfactory sense/ feeling the texture in the mouth/ feeling of body • Feelings & emotions (e.g. happy, unhappy, negative, positive, upset, confused, uneasy, frightened, angry) • Memories & experiences (e.g. reminiscences, significant events, moments of beauty, re-experiencing a past event such as childhood memories, unsolved problems, associations to music such as memories of a wedding) • Fantasies (e.g. dream images) • Metaphorical fantasies (a story or sequence of images) • Stream of consciousness (deep in the subconsciousness, depth consciousness) • Relaxation & concentration • Transpersonal experiences and imagery (e.g. “the person becomes the bird in flight”)

	• Peak & spiritual experiences • Parapsychological (insights) • Experiences of healing energy • Infilling with positive qualities (e.g. love, joy, goodness) • Resolution of painful memories, cleansing, rebuilding or repairing of the body, growth or positive transformation of images • Insightful moments, moments of gratitude • Unpleasable feelings: unsolved problem/ personal event, memories of embarrassing moments, fear, anger, conflicts, stressful moments

Table 2: Types of imagery experiences and function of organs, objects and mind

When adopting the principle of mindfulness within GIM, processes such as a dynamic process can be observed in a mindfulness way - focusing moment by moment, being nonjudgmental, having nonattachment (or being non-striving) and letting go. In this way, certain principles of mindfulness and MBP approaches can be integrated into the psycho-music therapy process and support the GIM process.

Furthermore, MBP and music therapy can both offer a spiritual and creative experience (Aldridge, 2003; Carmody et al., 2008; Lipe, 2002; Tsiris, 2018), and these experiences can develop personal insight. The concept of insight has been discussed in music therapy literature (Amir, 1993; Wheeler, 1987). Wheeler (1987) categorises music therapy procedures into three levels: a) music therapy as activity therapy; b) insight music therapy with reeducative goals; and c) insight music therapy with reconstructive goals. Amir (1993) found that insights happened when both client and therapist were creatively engaged in the here-and-now moment.

Insight can be defined as the "capacity to gain an accurate and deep understanding of someone or something" (Oxford Dictionary Online, 2017). In the mindfulness tradition, insight (vipassanā, 慧) is the significant factor within self-awareness because it can naturally lead to the expansion of self-knowledge and understanding of the authentic self (Vago, 2014). These feelings of the authentic self can be associated with personal spiritual nourishment.

During the inner exploration of MBP and music therapy (e.g. GIM processes), clear thinking, greater conscious awareness, altered states of consciousness, and a purified mental state may have occurred and this may be viewed as a type of spiritual moment. In the GIM, through the inner musical journey, a different state of mind may be created, and a profound transformation may have happened (Summer, 2011). Bonny (2010) highlighted that the client reaches a deeply relaxed state while listening to the music and creating imagery and this can possibly expand our consciousness and lead to self-discovery. Through this process, the client can experience self-transformation.

Therefore, the process of 'self-exploration' or 'inner transformation' can be seen in both GIM and MBP. Both have similar goals including activating inner reflection and exploring the true self, promoting a different level of self-awareness and enhancing the sense of wellbeing whether by means of music, imagery or mindfulness experiences. All of these offer a plausible justification for the integration of MBP and GIM or, more generally, mindfulness-based music therapy as a psychodynamic music therapy approach.

Here and now, letting go, nonself, nonattachment and being nonjudgmental

Present moment awareness, letting go, impermanent self, detachment, nonjudgmental awareness and compassion are basic principles and components of mindfulness which may benefit therapeutic situations (Goldberg & Dimiceli-Mitran, 2010; Van Dort, 2015). Kononenko (2010) says, "the true purpose of Zen [mindfulness meditation] is to see things as they are, to observe things as they are, and to let everything go as it goes" (p. 312). Through embracing the principles of mindfulness, a new therapeutic perspective may be created in terms of the exploration of feelings, memories and thoughts, as well as in practitioner-client relationships. For example, in music therapy, the notions of nonself, nonattachment and being nonjudgmental facilitate this letting go in therapy work and moment by moment awareness that allows the music and imagery to move freely.

The concepts of mindfulness within music therapy have been discussed. The keynote speech by Bonny (2010) mentions, "in GIM the images are immediately told to the guide during the playing of the music thus bringing the experience into the 'here and now'." Grocke and Wigram (2006) consider that our emotions, ideas, sensations, thoughts, or images can be mindfully observed and explored. The mindful observer will let go of these thoughts or images, or let them pass, rather than trying to reject them. Van Dort (2015) adopts mindfulness in GIM sessions. For example, focusing on breathing the fresh air into the body and breathing out any negative emotions.

Van Dort (2015) also incorporates a mindfulness induction exploring the theme of 'egoless living and ego-based living' and 'acceptance of self and others.' She mentions, "actions or living that come from selflessness are more spontaneous, useful and generous" (p. 228). Mindfulness is beneficial for changing one's experience of self and helps to better understand the concept of non self-centric states of being. This egolessness can be considered either as a form of self-extension which may include extending the self to include other people, groups, material objects, institutions, geographical regions, and work (Lancaster & Foddy, 1988), or else as nonself, which is a central concept of mindfulness.

In traditional mindfulness practice, existence can be understood as three basic facts which are impermanence (anicca), suffering (dukkha) and nonself (anattā). A deep awareness of these 'three characteristics of existence (tilakkhaṇa)' can expand the understanding of the nature of the phenomena that exist in this world. Contemplation of these basic facts is used to cultivate insight and pursue true happiness. Here, true happiness can be understood as the feeling of authenticity and freedom achieved by transforming suffering into peace and joy (Hahn, 1999, 2008). MBP can also empower self-esteem and generosity when observing ourselves and others, and these attitudes affect our potential for egoless living.

To conclude this section, the manifestation of mindfulness includes a feeling of dignity about ourselves and this may in turn also bring a feeling of inner freedom and self-worth. The ultimate aims of mindfulness practice are to understand the essential meaning of existence and cope with life's stresses and difficulties. In relation to therapeutic work, the principles of mindfulness afford the opportunity and offer the ability for a client to gain new perceptions and attitudes towards old thinking and behavioural habits (including ego-based living versus egoless living; holding on versus letting go; dwelling on memories or feelings versus nonattachment to memories and feelings; being critical of self and others versus non-judging). Therefore, integrating the principles of mindfulness into music therapy can provide a fresh outlook on ourselves and to the therapeutic relationship, and can give both

clients and therapists the opportunity to explore meaning in life (depending on individual circumstances) and discover the authentic self as a fully functioning person (Rogers, 1995, 2012).

CONCLUSIONS

In this paper, I have offered a comprehensive overview of previous studies on integrating mindfulness and music. Each study presents a wide range of theoretical and practical evidence for combining mindfulness with creative performing artists, therapists as well as musicians. The findings reveal that there has been a growing recognition for the benefits of integrating MBP and music within various groups such as those with drug and alcohol dependencies, Huntington's disease, breast cancer, Alzheimer's disease, Autism spectrum disorder and symptoms of depression and emotional stress (Eckhardt & Dinsmore, 2012; Grocke & Wigram, 2006; Innes et al., 2017; Lau, 2011; Lesiuk, 2015; Van Dort & Grocke, 2013). Furthermore, I have attempted to provide a theoretical framework for combining MBP and music therapy. Firstly I discussed existing psychodynamic approaches of music therapy and MBP and secondly focused on exploring potentially shared core concepts and therapeutic factors. With regards to this, several key principles, psychodynamic perspectives, and approaches between MBP and music therapy were identified.

Although various aspects of the themes were discussed, considering the limitations of this study, further research is needed to explore the similar concepts, core principles and approaches such as the person-centred approach and the therapeutic relationship. Further to this, a more rigorous empirical study is required to examine the relationship between mindfulness practice and music therapy in various healthcare settings whether as a main clinical treatment or as a supportive treatment. Nevertheless, the outcomes of this study show that MBP and music therapy can provide meaningful collaborative sources in the healthcare service as well as the value of combining MBP and music and/or music therapy within multidisciplinary teamwork. Developing an understanding of these relationships between MBP and music therapy will contribute to building a more solid theoretical framework for combining MBP and music therapy, and it will bridge the gap between theory and practice.

There are many ways to cultivate happiness and health; MBP and music therapy, whether experienced independently or integrated, can benefit health and wellbeing (Diaz, 2010, 2013; Hwang, 2018; Lin et al., 2008; Medcalf, 2017; Rodríguez-Carvajal & de la Cruz, 2014; Vidyarthi et al., 2012). Mindfulness can be a guide to find inner silence and space to connect with the true self and music therapy can bring about an experience of certain states of mind (spiritual consciousness) through authentic feelings. As shown, music therapy and MBP have potential integrative aspects and these are valuable healing resources for the mind-body-spirit connection that can enhance spiritual wellbeing and growth.

ACKNOWLEDGEMENT

The author wishes to thank Dr Leslie Bunt who made this study possible and Dr Giorgos Tsiris and the editorial and reviewing team at Approaches for all the care, encouragement, and advice at every step of the way.

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APPENDIX: SUMMARY OF REVIEWED ARTICLES

Notes: Active (A); Beck Anxiety Inventory (BAI); Bull's Mental Skills Questionnaire (BMSQ); Computer-assisted qualitative data analysis software (CAQDAS); Cognitive Interference Questionnaire (CIQ); Competitive State Anxiety Inventory-2 (CSAI-2); Continuous Response Digital Interface (CRDI); Control group (CG); Digit-Symbol Substitution Test (DSST); Experiment group (EG); Five Facet Mindfulness Questionnaire (FFMQ); Kenny Music Performance Anxiety Inventory (K-MPAI); Langer mindfulness scale (LMS); Memory Functioning Questionnaire (MFQ); Mindful Attention Awareness Scale (MAAS); Mindfulness-based music therapy (MBMT); Music Performance Anxiety Inventory for Adolescents (MPAI-A); Music Performance Anxiety (MPA); Music Performance Quality Rating Form (MPQ); No, of participants (N); Not Reported (NR); Perceptions of Success Questionnaire (POSQ); Performance Anxiety Inventory (PAI); Performance Anxiety Questionnaire (PAQ); Performance-related Musculoskeletal Disorders Questionnaire (PRMD-Q); Performance-related Musculoskeletal Disorders (PRMDs); Profile of Mood States Brief Form (POMS Brief); Progressive Muscle Relaxation (PMR); Receptive (R); Randomized Controlled Trial (RCT); Ryff's Psychological Well-Being Scales (PWB); Smith Relaxation States Inventory (SRSI); State Anxiety Inventory (SAI); State-Trait Anxiety Inventory (STAI); Trail-making Test (TMT).

Author(s), year	Methods	Key words	Interventions	Outcome measures and data analysis	Duration (session, interview length)	N	Type participant	Key message (related to integrated intervention)	Source and country
Baird (2016)	Qualitative	Meditation, Music performance, Anxiety	Meditation, Breathing techniques, Yoga, Performance visualization	Focus group, Interviews, Post-performance, Group discussion, Participant journals, Open-ended survey	10 minutes of meditation (4 weeks)	6	Undergraduate and Graduate music students	Meditation is a useful tool to reduce music performance anxiety and produces positive changes in mental attitude.	*PhD Thesis* (USA)
Brown (2011)	Qualitative case study (Autoethnography)	Flow, Mindfulness, Music performance	Focused attention and mindfulness, Music performance	Personal journals, Mindfulness, Documentation, Piano accompanist experience	Autobiographical account of 40 years of work	1	Self-reflection for researcher	There is a strong link between mindfulness and flow (music performance).	*Studies in Learning, Evaluation, Innovation & Development* (Australia)
Fidelibus (2004)	Qualitative	Improvisation, Music therapy, Mindfulness	Listening and playing music, Mindfulness, Improvisation	Interviews, Observation, Questionnaires, Interpretation, Focus Groups, CAQDAS	1 hour - 1.5 hours session (10 times)	10	Adults; Male (n=5), Female (n=5)	Mindfulness gives a new outlook to music therapists and can be a useful tool in music therapy.	*PhD Thesis* (USA)
Lesiuk (2016)	Qualitative	Music therapy, Mindfulness, Cancer, Attention, Mood	MBMT, Music experience, Mindfulness Attitude, Homework	Observation, Discussion, Interpretation, Focus Groups, Narrative responses	1 hour session,15 - 20 minutes of meditation, Homework (4 weekly)	15	Adults; Female, breast cancer	Mindfulness and music therapy are a valuable intervention for breast cancer.	*Healthcare* (USA)
Lau (2011)	Qualitative	Mindfulness, Music therapy, Awareness, Openness	Mindfulness, Music therapy (e.g. Improvisational music therapy)	Observations, Interviews, Journals of logs & memos, Recorded videotapes	30 minutes session (Twice a week, for 3 months)	1	Autism spectrum disorder 12-years old boy	Mindfulness is a promising subject that could contribute valuable attributes to music therapy and other multidisciplinary health fields.	*Master Thesis* (USA)
Mika (2011)	Qualitative	Music therapy, Mindfulness, Therapeutic attitude, Silence	Music therapy, Mindfulness, Mindfulness-based therapies	Interview, Focus Groups, Open-ended discussions	52;25;36 minutes (Interview); 1hour 20minutes (Discussion)	7	Music therapists	Mindfulness is a great benefit to music therapists who work in a clinical setting.	*Approaches: Music Therapy & Special Music Education* (UK)
Medcalf (2017)	Qualitative	Music therapy, Mindfulness, Empowerment	Music therapy, Mindfulness practice	Interviews, Focus Groups	NR	4	Four music therapists (1 male, 3 females)	Mindfulness-based approach and music therapy might support one another.	*Australian Journal of Music Therapy* (Australia)

Robarts (2009)	Qualitative	Mindfulness, Music therapy, Psychotic child	Music, Music therapy, Mindfulness	Observation, Interpretation	30 minutes session 1 (once a week) (for 3 years)	14-years old girl	Music can regulate the core of our being. Combining music with mindfulness can support and transform the distorted and disrupted foundations of the bodily-emotional self.	*Exploring the basis of human companionship* (UK)
Van Dort & Grocke (2013)	Qualitative	Music, Imagery, Mindfulness	Mindfulness relaxation, Music listening, Imagery, Mandala drawing or writing	Focus Groups, Observation, Discussion, Interpretation	90 minutes session NR (Every two weeks for 10 weeks)	People in an outpatient drug and alcohol rehabilitation facility	Integrating mindfulness and music therapy have positive effects for people who are living with drug and alcohol addictions.	*In: L. Rappaport (ed.), Mindfulness and Arts Therapies* (Australia)
Hwang (2018)	Qualitative	Relaxation techniques, Mindfulness meditation, Relaxation music, Healthcare	Relaxation techniques, Mindfulness meditation, Relaxation music	Focus group, Interviews, Discussion, Open-ended interview	1 hour - 1.5 hours (interview) (12 interviews per participant), Data collection (5 months), Data analysis (7 months)	Music therapists, Meditation expert, Medical practitioners	There is a growing interest in integrating health and mind-body care. Music and mindfulness can be regarded as a potential treatment for improving health-related quality of life and can also be beneficial in various healthcare settings.	*PhD Thesis* (UK)

Table 3: Qualitative studies of integration of mindfulness and music

Author (s), year	Methods	Key words	Interventions	Outcome measures &(Session, Data analysis Interview length)	Duration	N	Experiment group Control group	Type &participant	Key message (related to integrated intervention)	Source & country
Chang et al. (2003)	Quantitative	Meditation, Music performance anxiety	Meditation, Music performance	PAI, SAI, CIQ, Paired t-test	8 weeks meditation classes (3 months)	19	Experiment Group(n=9), Control group(n=10)	University Students	Meditation may be a useful tool for aiding performers to combat performance anxiety.	Medical Problems of Performing Artists (USA)
Diaz (2013)	Quantitative	Aesthetic response, Attention, CRDI, Flow, Mindfulness	Mindfulness meditation, Music listening	CRDI, Questionnaires, Likert-type scales	15 minutes of mindfulness, 10 minutes of 50 second music listening	132	4 focus group[2]	Undergraduate and graduate students	Mindfulness helps to increase the ability to focus on the music, and mindfulness influences the listening experience.	Psychology of Music (USA)
Diaz (2010)	Quantitative	Aesthetic response, Attention, CRDI, Flow, Mindfulness	Mindfulness, Attention music listening	CRDI, Questionnaires, Likert-type scales	15 minutes mindfulness, 10 minutes 50 second music listening	132	4 focus group[3]	Undergraduate and graduate students	Mindfulness increases the degree of peak responses and it helps to increase the ability to focus on the music.	PhD Thesis (USA)
Farnsworth-Grodd (2012)	Quantitative [longitudinal study]	Mindfulness, Music performance anxiety, Perceptions of performance quality, Music performance students	Mindfulness-based intervention	STAI-T, ASI-3,CES-D,PAI,FFMQ,PA I,CBMP,RIES,C DMP, PEPQ, Questionnaire, Four-point Likert scale	Three self-report online surveys (Over a 4 month semester period)	159	Focus group	Music performance students	" An understanding of how a mindfulness-based intervention could increase act with awareness and associated adaptive coping strategies is especially important if we are to make progress in developing effective coping related interventions to reduce music performance anxiety" (p.197).	PhD Thesis (New Zealand)
Innes et al. (2017)	Quantitative	Alzheimer's disease, Cognitive impairment, Early memory loss, Memory	Kirtan Kriya meditation (KK), Music listening (ML)	MENDTM Protocol, Observation, MFQ, DSST, TMT A/B	6 months study	53	Meditation group/Music listening group (n= 53)	People with Alzheimer's disease	" ... meditation or ML can significantly enhance both subjective memory function and objective cognitive performance in adults with SCD, and may offer promise for improving outcomes in this population" (In Abstract).	The Journal of the Alzheimer's Association Alzheimer's & Dementia (USA)

[2] Mindfulness induction & Aesthetic response (n=34), Mindfulness induction & Flow response (n=35), Aesthetic response (n=32), Flow response (n=31).

[3] Ibid.

Lesiuk (2015)	Quantitative, [longitudinal study]	Music listening, Mindfulness exercise, Breast cancer, Attention, Mood	Music activities & mindfulness attitudes, Weekly homework	Conners' Continuous Performance Test II, Profile of Mood States-Brief Form	1 hour per week (4 weeks)	15	Stage I (n=2), Stage II (n=6), Stage III (n=7)	15 women with a diagnosis of breast cancer	" A preferred music listening and mindfulness exercise may be offered to women with breast cancer who experience attention problems and mood distress" (In Abstract).	Oncology nursing forum (USA)
Lin et al. (2008)	Quantitative	Acceptance, Buddhism, Mindfulness, Musical performance anxiety, Vipassana	Musical instruments, Mindfulness meditation training (Breathing techniques)	SAI, PAI, MPQ, MANOVA, SPSS 8.0	1 hour and 15 minutes of meditation (8 weeks), 5-10 minutes of musical performance	19	Meditation group (n=9), Control group (n=10)	Undergraduate and graduate students (5 males and 14 females)	" … a decrease in musical performance anxiety was associated with meditation" (p.146) " In the meditation group, a positive correlation is found for performance quality […]and performance anxiety" (p.148).	Psychology of music (USA)
Steyn (2013)	Quantitative	Psychological skills, Music, Mindfulness, Acceptance and commitment approach	Psychological skills training, Mindfulness (The MAC approach)	PWB, CSAI-2, BMSQ, FFMQ, POSQ, K-MPAI, Self-theory Questionnaire	Outcome measures (Over 6 weeks period)	36	Experimental group (n=21), Control group (n=15)	Undergraduate music students	" … the intervention [PST & MAC] programme had a moderately significant impact on important psychological dimensions of the participating undergraduate music students" (p.20).	PhD Thesis (South Africa)
Tomaselli (2014)	Quantitative	Mindfulness-based music listening, Anxiety, Older adults	Live music-accompanied body scan, Mindful music listening	BAI, MAAS, Pre and Post-test, Likert scale	15 minutes of music & body scan, Discussion, Mindfulness instruction (Twice a week-7days)	20	Experimental group (n=10), Control group (n=10)	Older adults (2 males and 18 females)	A live music-accompanied mindful body scan would decrease the anxiety symptoms and increase the mindful awareness of older adults.	PhD Thesis (USA)
Khalsa et al. (2013)	Quantitative	Music performance anxiety, Yoga, Adolescent	Classical yoga postures, Breathing techniques, Meditation	PAQ, MPAI-A, STAI, PRMD-Q, Evaluation of the yoga program	60 minute yoga classes (once a week for 6 weeks)	135	Experimental group (n=84), Control group (n=51)	Adolescent musicians	Yoga may be a promising way for adolescents to reduce music performance anxiety.	Alternative Therapies in Health and Medicine (USA)
Stern et al. (2012)	Quantitative	Yoga meditation, Music performance anxiety	Yoga classes, Daily home practice	PAQ, KMPAI, POMS Brief, STAIT Home practice log, Yoga program, Questionnaire	1-hour class (2times per week over 9 weeks), Daily home practice	24	A focus group	Adult students	Yoga meditation is a promising intervention for music performance anxiety in conservatory students	Medical Problems Performing Artists (USA)

Table 4: Quantitative studies of integration of mindfulness and music

Author(s), year	Methods	Key words	Interventions	Outcome measures & Data collection	Duration (e.g., session) Follow-up period	N	Experiment group & Control group	Type participant	Key message (related to integrated intervention)	Source & country
Langer et al. (2009)	Qualitative+ Quantitative Study (1)	Creativity, Music, Orchestra, Mindfulness	Music performance, Mindfulness, Music listening[4]	MAAS, LMS, Paired t-test, 10-point Likert-type scales	Play the finale from Brahms' Symphony No. 1(Twice)	203 s	Symphony orchestra members (n=60) + Local community chorus members (n=143), (51 men, 92 women)	Musicians	By staying in the present while playing, orchestral musicians may be able to take advantage of new opportunities and amend their performance to make use of physical, emotional, psychological, and environmental changes. Mindfulness can lead to music that both orchestral musicians and listeners prefer.	Psychology of Music (USA)
Langer et al. (2009)	Qualitative+ Quantitative Study (2)	Creativity, Music, Orchestra, Mindfulness	Music performance, Mindfulness, Music listening[5]	MAAS, LMS, Paired t-test, 10-point Likert-type scales	Play two pieces; a) Polonaise b) March of the Toys (Multiple times)	157	Symphony orchestra members (n=71) + Trained musicians (n=86), (29 men, 57 women)	Musicians		

Table 5: Mixed-method studies of integration of mindfulness and music

[4] [Study 1] Brahms's Symphony No. 1

[5] [Study 2] (1) 'Polonaise' from Christmas Eve by Rimsky-Korsakov
(2) 'March of the Toys' from Babes in Toyland by Victor Herbert

Author(s), year	Methods	Key words	Interventions and approaches	Outcome measures and data collection methods	N	Key message (related to integrated intervention)	Source and country
Baer (2003)	Literature based research methodology	Mindfulness, meditation, Meta-analysis, Treatment outcome	Varied interventions, approaches and duration based on multiple theories	Computer-based literature searches, Literature based data analysis	22 publications (Databases)	Mindfulness-based interventions may be helpful in the treatment of several disorders.	Psychology: Science and practice (USA)
De Felice (2004)	Literature based research methodology	Affective neuroscience, Musical performance anxiety, Mindfulness	Previously varied literatures related to mindfulness meditation and musical performance anxiety	Literature based data analysis	Varied previous studies	"Regulating MPA with Mindfulness Meditation promises to have a significant impact on musical performance skills" (in abstract).	PhD Thesis (USA)
Vidyarthi et al. (2012)	Research through design	Mindfulness, Sound, Music, Self-regulation, Stress, Psychology, Biofeedback, Research through design	Mindfulness, Sound, Mindfulness progressively controls sound through respiration	Theoretical based data analysis, Focus group, Discussion, Questionnaire, Observational rating, Before and after the sonic cradle experience, Respiratory biofeedback sensors	15 publications (Databases)	Sonic Cradle might foster a meditative experience to participants by following a specific attentional pattern characteristic of mindfulness.	Proceedings of the designing interactive systems conference (Canada)
Eckhardt & Dinsmore (2012)	Theoretical based study	Music listening, Mindfulness, Meditation, Depression, Self-awareness, Counselling, Creativity	Mindful Music Listening (Combining music listening and mindfulness practice), Mindfulness Practice (Similar to mindfulness-based stress reduction)	Theoretical based data analysis, Observations, Interpretation, Discussion	Varied previous studies	Mindful music listening is a potential intervention for depression. The mindful exploration of emotions evoked by music listening may help a quiet client to disclose, enabling the client to label, express, and manage emotions.	Journal of Creativity in Mental Health (USA)
Rodríguez-Carvajal & de la Cruz (2014)	Literature based research methodology	Mindfulness, Meditation, Music, Performers, Audience	Mindfulness meditation, Music, Musicians	Computer-based literature searches, Literature based data analysis	27 publications (Databases)	Mindfulness can be characterised by an important interaction with the art of music in many contexts, thus deserving research and exploratory applications.	International Journal of Behavioral Research & Psychology (Spain)

Oyan (2006)	Theoretical based study	Mindfulness, Music performance, Anxiety, Creativity	Mindfulness meditation (Formal/Informal practice)	Computer-based literature searches, Literature based data analysis	Varied previous studies	The practice of mindfulness may be one way of learning to feel and accept what is happening in the present moment, and ultimately this attitude is applicable to music performance.	*PhD Thesis* (USA)
Xu H (2010)	Theoretical based study	Music performance, Anxiety, Zen meditation, Musician	Zen meditation, Musical performance	Computer-based literature searches, Literature based data analysis/theoretical based data analysis	Varied previous studies	Zen meditation can be a useful and practical method for improving musicians' relationship to their performance and for overcoming performance anxiety.	*PhD Thesis* (USA)
Grocke & Wigram (2006)	Theoretical based study (Using case sample)	Mindfulness, Music therapy	SRSI, PMR (Shortened version), Mindfulness relaxation (Amended version)	Theoretical based data analysis, Mindfulness approach, Nature sounds CDs (Forest sounds from the series *Echoes of Nature*)	54-year-old man with Huntington' s disease (HD)	Integrating mindfulness approach into music therapy can be useful for people with Huntington' s disease.	*London; Philadelphia: Jessica Kingsley Publishers* (UK & USA)

Table 6: Theoretical based studies of integration of mindfulness and music

Ελληνική περίληψη | Greek abstract

Ενσωματωτικές προοπτικές για την ενσυνειδητότητα, τη μουσική και τη μουσικοθεραπεία: Μία βιβλιογραφική επισκόπηση

Mi hyang Hwang

ΠΕΡΙΛΗΨΗ

Με την αυξανόμενη αναγνώριση του πλεονεκτήματος της εργασίας εντός μιας πολυεπιστημονικής ομάδας και μιας διεπιστημονικής μελέτης της υγείας, η συμπερίληψη της μουσικής και της ενσυνειδητότητας σε ποικίλους επιστημονικούς τομείς της υγείας έχει γίνει πλέον πιο κοινή. Σκοπός της μελέτης ήταν η διερεύνηση της θεωρίας και της πρακτικής ενσωμάτωσης, των βασικών αρχών και της ψυχοδυναμικών προοπτικών αναφορικά με τη μουσικοθεραπεία και την ενσυνειδητότητα. Τριάντα άρθρα επιλέχθηκαν από ηλεκτρονικές βάσεις δεδομένων και γκρίζα βιβλιογραφία. Δεν συμπεριλήφθηκαν περιλήψεις συνεδρίων και άτυπες ανασκοπήσεις της βιβλιογραφίας. Τα άρθρα κατηγοριοποιήθηκαν και αναλύθηκαν σύμφωνα με τις μεθόδους, τις παρεμβάσεις, τα μέτρα έκβασης και τα κύρια νοήματα. Τα κύρια αποτελέσματα από τις έρευνες έδειξαν ότι η ενσωμάτωση της ενσυνειδητότητας και της μουσικής μπορεί να ενισχύσει τη μουσική εμπειρία, να διευκολύνει τη μουσικοθεραπευτική διαδικασία (π.χ. Guided Imagery and Music), και να συνεισφέρει στην ψυχική ευεξία (π.χ., μείωση του άγχους, συναισθηματική στήριξη και αυτεπίγνωση). Βάσει της ανάλυσης των δεδομένων εντοπίστηκαν δύο κεντρικές θεματικές ενότητες: α) ψυχοδυναμικές προοπτικές της ενσυνειδητότητας και της μουσικοθεραπείας, και β) εδώ και τώρα, αφήνοντας, μη εαυτός, μη προσκόλληση και όντας μη επικριτικός. Η σύνδεση ανάμεσα στη μουσική και στην ενσυνειδητότητα έχει αναγνωριστεί τις τελευταίες δεκαετίες, και ο συνδυασμός μουσικής και ενσυνειδητότητας έχει επιδείξει θετικά αποτελέσματα στη βιβλιογραφία. Τα αποτελέσματα φανέρωσαν αρκετές βασικές προοπτικές και προσεγγίσεις ανάμεσα στην πρακτική που είναι βασισμένη στην ενσυνειδητότητα (mindfulness-based practice, MBP) και στη μουσικοθεραπεία. Αυτά τα αποτελέσματα μπορούν να προσφέρουν μία νέα ματιά στη θεραπευτική σχέση και να παρέχουν ένα πρακτικό και θεωρητικό πλαίσιο για τον συνδυασμό της ενσυνειδητότητας και της μουσικοθεραπείας.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

μουσική και ενσυνειδητότητα, μουσική, μουσικοθεραπεία, ενσυνείδητος διαλογισμός

Approaches: An Interdisciplinary Journal of Music Therapy
15 (1) 2023

ISSN: 2459-3338 | www.approaches.gr

COMMENTARY

A commentary on "Integrative perspectives on mindfulness, music and music therapy: A literature review" (Hwang)

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AUTHOR BIOGRAPHY

Jo Parsons received an Honours BMus in Music Theory and Composition from Memorial University in 2009 and completed the Master of Music Therapy program from Wilfrid Laurier University in 2011. During her career she has worked with adults in long term care, children in education and socially labelled vulnerable groups and communities. Her practice has taken her to a variety of countries including Canada, Nepal, Uganda, and her current location in Devon, England where she works in the mainstream school system. Jo is a PhD student at Nordoff Robbins Music Therapy/Goldsmiths University. Her research is practice based, regarding her work within mainstream education. [jo.parsons@nordoff-robbins.org.uk]

Publication history:
Submitted 26 Oct 2021
Accepted 15 Mar 2022
First published 25 Apr 2022

This commentary is in response to Hwang's article "Integrative perspectives on mindfulness, music and music therapy: A literature review" which was published in August 2021 in Approaches. The concept of mindfulness is rooted in Eastern philosophical and religious traditions, particularly Buddhism. Its practice focuses on being in the present, with a non-judgemental attitude to ones thoughts. Chugyam Trungpa described it simply as, "making friends with yourself" (Trungpa & Gimian, 2016).

For many decades now, mindfulness and other Eastern philosophical traditions have been applied to the growing world of 'wellbeing' in the West. While research into such integration is still in its early stages, there is a growing evidence base for its effectiveness, particularly within psychotherapy and psychology. The Academic Mindfulness Interest Group (2006) noted such benefits to include: pain management, decrease in mood disturbance and stress, improvement in quality of life and a reduction in anxiety and depression,

Music and health related disciplines have developed over the last century, resulting in a wide range of practices. Coupled with the notion that mindfulness and spiritual practices have long been connected to music and sound, it is not surprising that there has been an intersection of mindfulness and arts-based therapy (and other arts and wellbeing work). Rappaport (2014) edited a comprehensive book on mindfulness and the art therapies, which covered the context of mindfulness, its integration into practice, the approaches involved and its application in education and training. Additionally, Hanser (2016) wrote about music therapy in the context of integrative health, including the spiritual aspect of one's experience of health.

In Hwang's article, there is a recognition of the growing interest in interdisciplinary wellbeing work and the need to reflect, not only on the dissemination of research outcomes, but on the theoretical frameworks and perspectives that are involved in the integration of mindfulness into music and health practices.

Hwang begins by highlighting the prevalence of Mindfulness Based Practices (MBP) in healthcare, and in particular music and healthcare work – this includes but is not limited to music therapy. The outline of the existing literature is organised into various categories which is helpful in understanding the approaches influencing how people working in music and health fields integrate MBP into their practices. The majority of studies, particularly where music therapists utilise aspects of MBP in practice, have highlighted why combining MBP and music/health practices may be beneficial. However, I have noted that few have discussed the therapist's relationship to the broad notion and practice of mindfulness, the theoretical implication of integrating it into practice, and the resulting methodological choices in relevant research.

In interdisciplinary work, in relation to the literature gap I have noted, practices and techniques can sometimes be pulled from one disciplinary practice to another with little consideration of the ontological or theoretical origins. Instead, an emphasis is placed on evidence from research that has deemed particular practices and techniques as effective. As a music therapist myself, with a focus on sociological and ethnography-inspired research, I tend to critically consider the effects of 'boxing up' music into interventions. As a keen amateur in meditation, I have the same wonderments towards mindfulness. As a complex practice that is integrated differently into each individuals day-to-day life, what may be the effects of seeing such a concept as an intervention - or a model to be used as an add on to an existing practice?

In Hwang's review of the research undertaken in mindfulness and music therapy, it is clear that both mindfulness, music and the combination of the two have often been studied as interventions with a set duration. The methodological approaches vary from qualitative, to quantitative, to mixed method and theoretical based studies, but, as previously mentioned, very few of these articles mention the theoretical underpinnings of the chosen methods of research.

The described methods in Hwang's review mostly involve post-practice retrieval of effects (e.g., interview, questionnaire, scales, inventories) and I am left wondering about the practices of music, music therapy and mindfulness and how they are enacted by people to garner such effects. As DeNora and Ansdell (2017), suggest, focus is needed on the 'black box' of how music 'gets into' action (p.231). I would argue this is also needed for mindfulness and its application within music and health practices.

Hwang begins to address this by focusing on particular types of methods within music therapy (namely within a psychodynamic approach), such as Guided Imagery and Music (GIM). The processes involved in GIM are outlined and then compared to those involved in meditation practices of mindfulness:

> When adopting the principle of mindfulness within GIM, processes such as a dynamic process can be observed in a mindfulness way – focusing moment by moment, being non-judgmental, having non-attachment and letting go. (Hwang, 2021, p. 12)

Described in this way, mindfulness is not broken down into an intervention and applied in GIM practice, but instead music and people's engagement with music is seen as inherently mindful – or a natural practice of mindfulness.

In the second half of presenting the results, Hwang has started to unpick aspects of mindfulness and such spiritual practices that seem to align with music therapy and music-health work (here and now, letting go, non-self, nonattachment, nonjudgemental). This is a helpful step in understanding how people may view and use these concepts in practice. In a study of spirituality and music therapy, Tsiris (2018) first developed a knowledge base around people's understanding of spirituality and its place within their work – this inspired a further study as to how spirituality is actually enacted within practice, in situ.

Hwang finishes the article with a call for knowledge development on the themes already pulled out through this literature review. I believe further unpicking the themes inherent in mindfulness practice is a helpful step towards a greater understanding of how mindfulness, music and therapy may be theoretically and practically aligned.

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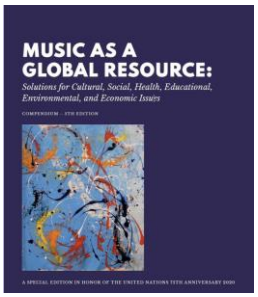
Approaches: An Interdisciplinary Journal of Music Therapy
15 (1) 2023

ISSN: 2459-3338 | www.approaches.gr

BOOK REVIEW

Music as a global resource: Solutions for cultural, social, health, educational, environmental, and economic issues (5th ed.) (Hesser & Bartleet, Eds.)



Reviewed by Hala Jaber

Independent scholar, Ireland

Title: Music as global resource: Solution for cultural, social, health, educational, environmental, and economic issues. **Editors:** Barbara Hesser & Brydie-Leigh Bartleet **Publication year:** 2020 **Publisher:** Music as a Global Resource **Pages:** 233 **ISBN:** 978-0-6450322-9-1

REVIEWER BIOGRAPHY

Hala Jaber is a Palestinian community musician. She has recently obtained her PhD Arts Practice (music) at the Irish World Academy of Music and Dance, UL, where she previously graduated from the MA Community Music programme. Her doctoral research examined community music approaches and informed practice when working with refugees and asylum seekers. She is also interested in understanding self-care practice in community music workshops when working in contexts of trauma. [jaber.hala@gmail.com]

Publication history:
Submitted 15 Mar 2021
Accepted 27 Mar 2021
First published 7 Jun 2021

The compendium “Music as a global resource: Solutions for cultural, social, health, educational, environmental, and economic issues” is a comprehensive document that includes many music programmes and projects from around the world. The layout and arrangement of the compendium make it accessible and easy to follow. There are five main sections in the resource: Music for physical and mental health and well-being; Music for quality education and lifelong learning; Music for social justice and equality; Music for cultural, community and environmental sustainability; and Music for peacebuilding and surviving trauma. Each project indicates a link to the UN Sustainable Development Goals, demonstrating that music-making and artistic projects can explore global issues.

Reading the compendium expanded my awareness of the multiple ways music is being used by various groups around the world to initiate and create change in society. The projects are very rich in their content and they bring forth much positive energy to the communities in which they operate. Engaging with this resource created in me the desire to travel and engage with these projects; a rich experience indeed would await me.

It is clear how the pandemic has affected the workings of the projects; some needed to pause their activities and others moved to online platforms. However, the resilience of the musicians and other project workers was evident in the efforts and drive to find ways to deliver music and be innovative in the use of technology to keep the music-making going.

The resource is easy to read as it is written in a non-academic manner. All the projects presented in the compendium follow a similar layout with a series of subheadings or answering project-specific

questions. This approach ensures that the main information of each project is clearly communicated and that there is a consistency throughout. The contact details of each project are available in the document as well as examples of the work.

I noted that the projects were all driven by the desire to create and work towards a more inclusive and welcoming community. Nevertheless, there were not many projects that collaborated with non-artistic organisations or institutions. The section showcasing environmental issues was the one in which I noted broader collaborations, mainly with scientific and environmental bodies.

The compendium contains projects, some of which are well-developed while others are still in their infancy, from many different countries. It was inspiring to notice that the primary goal and aim for most of the projects, regardless of where they are situated, was quite similar. The goals revolved around connectivity and representation. However, a distinct difference was present in the amount and depth of research and evaluation around the workings of the projects. The projects that were being supported or led by researchers in educational institutions had stronger research and evaluation outputs.

The projects presented in the document highlighted some gaps within the academic literature around community music, music therapy, and music education. I discovered some amazing projects and initiatives that I had not read about previously. This made me realise that the articles and book chapters I can access on this type of work are very limited in comparison to the large number of projects highlighted in the compendium. I would argue that this resource highlights the limitations around academic writings and the gap between practitioners and researchers. I started reflecting on whose work I am reading and why. Publishing in academia is challenging in terms of the rules and regulations that the person submitting an article needs to follow. As a result of this, some practitioners may not feel comfortable in trying to put their work in the academic domain. This made me understand more clearly the importance of documents such as this compendium. I wonder how we can bring forth practitioners' voices and experiences into the academic world, as I believe researchers can learn much from accessing texts such as this.

Reading the compendium made me also think about a societal issue that many projects and individuals across different countries are facing. Being different in our society can mean being silenced, excluded, shunned, and, at times, discriminated against. The concepts of connection, reconnecting with society, finding (and raising) one's voice, and being accepted are themes found in many of the projects. This issue was more prominent in projects that worked with people with physical disabilities and mental difficulties. On reflection, I wonder if there is the scope for a musical programme that targets politicians and other decision makers with the hope that they would then promote positive changes to work towards a more accepting and diverse society.

A development from this publication is perhaps the creation of a world-wide music resource platform. In such an arena, musical projects could contribute experiences, ideas, tips, and advice that may be of use to others working in this way. Additionally, there could be a community where existing and new projects may post an issue they are facing and others may respond with potential solutions and problem-solving strategies they have used to deal with similar issues. This would truly move forward the idea of music as a global resource, the overarching title of this publishing project.

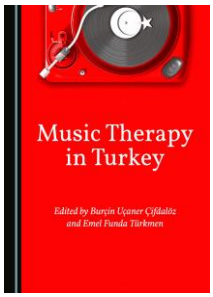
In closing, I would like to share a quote that resonated with me. This quote comes from the Project Chamber Scramble based in Hong Kong: “Music does not change the world, but it does change the people who change the world. Music empowers and emancipates; it strengthens and bonds the community. This is our source of hope in uncertainty” (p. 53).

Approaches: An Interdisciplinary Journal of Music Therapy
15 (1) 2023

ISSN: 2459-3338 | www.approaches.gr

BOOK REVIEW

Music therapy in Turkey (Çifdalöz & Türkmen, Eds.)



Reviewed by Fatma Nil Özalp

Independent scholar, Turkey

Title: Music therapy in Turkey **Editors:** Burçin Uçaner Çifdalöz & Emel Funda Türkmen **Publication year:** 2019 **Publisher:** Cambridge Scholars Publishing **Pages:** 115 **ISBN:** (10):1-52752446-9 / (13):978-1-5275-2446-0

REVIEWER BIOGRAPHY

Fatma Nil Özalp, MA is a researcher with a particular focus on music and health. Nil's special interest in better understanding the effects of music in human life led her to research and publish on the subject. She has experience of working with patients and medical surgeons. She practises as a researcher at the training and research hospital in Muğla, working with medical oncologists. She presented her clinical work at the European Music Therapy Congress in 2016 and the World Music Therapy Congress in 2014. She is a co-founder of Researchturk RTD Company and also works at the music department of Fine Arts High School in Muğla, Turkey. [nil.ozalp@researchturk.com]

Publication history:
Submitted 27 Jan 2021
Accepted 17 Feb 2021
First published 10 Apr 2021

An intrinsic part of Turkish culture, the relationship between music and health dates back to pre-history and the time of shamanism. The practice of using music as a tool for healing has long been part of old Turkic tradition, and today, it remains a traditional element. Scientific requirements for the use of music as a therapy, however, have not yet been met in Turkey.

In recent years, some activities have been organised to raise awareness of music therapy. One of these was the 7th International Hisarlı Ahmet Symposium. It was held with the title "Music Therapy" in 2016. The chapters in this book have been chosen from the papers presented at this symposium. The book is comprised of seven chapters. Each chapter is significantly different and independent from each other in terms of topic, method, and content. Except for the first three, the other chapters seem inconsistent considering the title of the book. Below, I give a brief outline of the chapters in three sub-sections before offering a critical evaluation of the book.

OUTLINE

Music therapy studies in Turkey

The first chapter is presented by Burçin Uçaner Çifdalöz. She briefly outlines the progress and current state of music therapy studies in Turkey. The study consists of the analysis of theses and articles

written between 1985 and 2016 which are listed in the official site of the National thesis database. The most notable finding is that the researchers only studied patients listening to music as music therapy. For readers who are curious about the general perception of music therapy in academic circles in Turkey, this finding is of interest.

In his chapter, ethnomusicologist Barış Gürkan considers "how the statement 'music therapy as a science discipline' positions its scientific boundaries between the two main paradigms of modernism, and postmodernism and how it is depicted in Turkey" (p. 22). Gürkan analysed which elements of the paradigms of modernism and postmodernism are used by music therapy and discusses the topic within the scope of a conceptual framework. The definition of what modernism and postmodernism concepts are and their relationship with science constitute the general focus of the study. He identified four different groups of researchers who conducted studies related to music therapy in Turkey. He found that there are major differences, refutations, and conflicts among distinct music therapy circles in Turkey as well as in their own methods. His study argues that there is not balanced progress in the study of music therapy in Turkey.

Practical music therapy studies

Özgür Salur investigates the clinical benefits of eclectic music therapy within a clinical environment involving six patients diagnosed with schizophrenia or schizophrenia-like disorders in a Turkish university hospital. This study appears to be the first case study in Turkey that is conducted by a music therapist. He has used musical games based on metaphors. Salur provides the details of the data gathering tools and describes the design of the study.

Giray Koçaslan introduces the history of the musical activities in a mental hospital called Powick Asylum by the famous composer Edward Elgar between 1879 and 1884 in Britain. Stating that the pieces which Elgar composed for the asylum have not been performed for many years, the author suggests that music therapy experts could conduct research concerning the use of these pieces today. The chapter also contains the tone and form analyses of the aforementioned pieces.

Psychologist Aslı Özyıldız gives a detailed analysis on the concept of "Sound Identity" developed by the Argentinian psychiatrist Rolando Benenzon. She emphasises that the listening skills of the therapist constitute an important point in the relationship between the therapist and the client.

Music therapy and education

Bilgehan Eren presents the philosophy, technical schema, application methods and techniques of the Orff-Schulwerk music therapy approach. He also discusses the instruments used and the session organisation in the approach in a detailed way.

The last chapter is written by Lilian Maria Tonella Tüzün. She summarises the development of music therapy in Brazil and details a music therapy practice carried out with refugee children in Sao Paulo. The author conveys the thoughts of four music teachers in the city of Afyon, Turkey, concerning the participation of their refugee students in the choir. It is not clear how the author links such musical activity with music therapy.

A CRITICAL EVALUATION

The title of the book, *Music Therapy in Turkey*, is both general and inclusive. It creates an expectation that the book will provide information concerning the historical background, current clinical studies, association activities, and music therapy education or certificated programmes in Turkey. However, only a small percentage of the content fulfils this expectation. Therefore, the title does not fully reflect the content of the book.

It would be beneficial to include discussions which could serve as a bridge between the topics for understanding the perspectives of the authors. Furthermore, it would be valuable for future potential editions if the editors could explain how the chapters relate to the book title and explore the implications of the book content. This disconnectedness constitutes the weakest aspect of the book. Moreover, the lack of methodology and systematic exploration, and the vagueness of the target audience can be noted as other weak points of the text. A strength is that the book is the collective product of work in the field of music therapy and that it reflects the opening steps of music therapy as a scientific discipline in Turkey. In spite of the fact that music has traditionally been used for *healing* on Anatolian lands for a very long time, the development of music therapy in Turkey, in terms of music therapy professionals and academic research publications, is not fully developed.

Recently, the Ministry of Health launched an initiative to recognise the field of music therapy. “Music therapy” was included as a subtitle in “Complementary Medical Practice” in 2016. In addition there have been attempts to offer music therapy certificates under specific courses by some private universities. There are two associations in Turkey: The Music Therapy Association (MUZTED) founded by Çifdalöz, who is one of the editors of the book, and most of the members of which are from the field of music; and the Applied Music Therapy Association (UMTED), with a membership mainly comprised of medical doctors. There is also a platform called the Music Therapy Academy which was founded by Özgür Salur who wrote one of the book chapters. The Music Therapy Academy and the associations have organised international and national activities, inviting expert speakers which have increased the awareness of the music therapy field in Turkey.

There were some events in Turkey held with the title “Music and Therapy” (i.e., World Music Therapy Day, 2020; Eskişehir; Evrensel ve Bilimsel: Müzik Terapi, 2019, Istanbul; Uluslararası Müzik Terapi Sempozyumu, 2016, Istanbul) and these are important for gathering international and national scholars, experts, students and institutions, and for raising awareness about what music therapy is or is not. At these events, I have observed that medical professionals have shown as much interest as the participants from the field of music. This is quite encouraging and serves as a valuable basis for developing the field of music therapy with the cooperation of medicine and music disciplines. In support of this interest, a study which determined the attitudes of 112 medical oncologists in Turkey concerning music therapy found that oncologists considered it positive to use music therapy for their patients (Aydemir & Tanrıverdi, 2014; Tanrıverdi & Aydemir, 2013). Musical interventions in which health workers or musicians are utilising music-based practices in dementia and end-of-life care in Turkey can be also counted as other examples of this interest (Çifdalöz, 2020).

As interest and awareness of music therapy in Turkey grows, international collaborations could increase, and the field could develop in accordance with the fundamentals of the profession of music

therapy. In the future, I anticipate that attention will also be given to developing music therapy education standards in Turkey.

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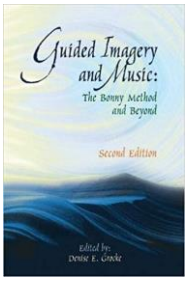
Approaches: An Interdisciplinary Journal of Music Therapy
15 (1) 2023

ISSN: 2459-3338 | www.approaches.gr

BOOK REVIEW

Guided Imagery and Music: The Bonny Method and beyond (2nd ed.) (Grocke, Ed.)



Reviewed by Maria Samara

Independent scholar, Switzerland

Title: Guided Imagery and Music: The Bonny Method and beyond **Editor:** Denise E. Grocke **Publication year:** 2019 **Publisher:** Barcelona Publishers **Pages:** 277 **ISBN:** 978-1-945411403

REVIEWER BIOGRAPHY

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Publication history:
Submitted 2 Apr 2020
Accepted 17 Nov 2020
First published 24 Mar 2021

Guided Imagery and Music: The Bonny Method and Beyond is the second edition of the original legendary 'blue book' that was first published in 2002, then edited by Kenneth E. Bruscia and Denise E. Grocke (Bruscia & Grocke, 2002). Seventeen years later, this inspirational book vividly mirrors the development and growth of the Bonny Method of Guided Imagery and Music (BMGIM). As Grocke states in her introduction, "this second edition gives clear evidence of how far the Bonny Method has travelled, through adaptations, expanded practice, a broadening of the understanding of the neuropsychology of the method, and impressive advances in research and fundamental evidence" (p. 6-7). This volume could easily be called a 'bible.' It is a valuable tool not only for Guided Imagery and Music (GIM) practitioners, students and music therapists, but a book that, due to its structure and content, is accessible to other mental health practitioners interested in broadening their knowledge and understanding in using new therapeutic tools and approaches. The book is divided into six parts, concluding with a set of appendices, where an updated list of Music Programs developed by GIM practitioners is presented.

Part One, (Chapters 1-4), provides us with core information on Helen Bonny's method, vision and its evolution through the years (Clark, Chapter 1). It is a detailed guide into the individual form of the method (Abbott, Chapter 2), the theories and concepts that "recognize and honor the wholeness of the individual, the fullness of life and the vastness of the universe" (Bruscia, Chapter 3, p. 47) and that are considered to be the foundation of Bonny's method.

Part Two, consists of 11 new or updated chapters (Chapters 5-15) regarding different applications of GIM across the life span. We see work with new client groups as well as new adaptations and modifications of GIM, which can meet the needs of diverse populations and situate GIM practice in new environments and therapeutic settings.

In her chapter "Guided Imagery and Music with Children and Young People", Band (Chapter 5) focuses on the value of effectively modifying the BMGIM to "make it a viable treatment modality for the youth" (p. 92). In Borling's chapter on addictions (Chapter 7), he links the 12-steps program with GIM practice, stressing that addiction work needs to consider interventions at the biophysical, psycho-emotional and psychospiritual levels in order for clients to progress toward true recovery. He suggests that GIM, with its psycho-emotional dimension, serves as a clinically compassionate and growth-oriented intervention, especially for those entering the second stage of recovery.

In Chapter 8, Beck explores research on the outcomes of GIM and its adaptations with clients with mental health challenges, focusing on the scope of changes in the psychiatric treatment around the world and the needs of these populations. Ahonen (Chapter 9) offers insight into the psychological and neurological rationale of using BMGIM and modified GIM programs as a tool with traumatised individuals. She gives suggestions as to contraindications of the method; the issue of safety is also raised, if not stressed, by other authors elsewhere. The core theoretical concepts, the evolution of Music and Imagery methods and interventions during and after cancer treatment, as well as how these are incorporated in the different levels of the treatment, are presented by Meadows and Burns (Chapter 11). Prominence is given to the value of third-wave therapies – GIM being one – that "support clients to experience the myriad and often conflicting emotions and thoughts that come with a cancer diagnosis and treatment" (p. 212).

A very interesting chapter on "GIM for Health and Well-Being in the Context of Physical and Medical Care" by Short (Chapter 12) provides us with a contemporary insight into the role of GIM practice in the treatment of physical health issues. A reviewed and updated form of the "Physical Marker Model" is re-introduced.

"Bereavement, Grief and Loss at End-of-Life" (Chapter 13), another very sensitive subject, is presented by Clements-Cortes. Since more and more people are embracing less traditional therapies in navigating the challenging symptoms associated with death and grieving, the author defines such terms as 'grief', 'mourning' and 'bereavement.' The last two chapters of this section focus on Group Guided Imagery and Music Therapy (Summer, Chapter 14) and Group Music and Imagery (Grocke, Chapter 15). Both authors provide us with an insight into groupwork development. The established schema of levels of practice (Summer, 1999; Wheeler, 1983) are addressed and the available literature since the *Music and Your Mind* book (Bonny & Savary, 1973/1990) is reviewed. Once again, it is interesting to note the increased amount of recent research and case studies supporting group work with this method since the first edition of this book.

Moving to the next part of the book, Part Three (Chapters 16-21), the reader finds a section with different orientations of the BMGIM practice, namely articles on Jungian (Stokes-Stearns, Chapter 16), psychodynamic (Bruscia, Chapter 17), Gestalt dream-work (Clarkson, Chapter 18), mentalization-based psychotherapy (Frohne-Hagemann, Chapter 19), metaphor and emotion regulation (Perilli, Chapter 20) and transpersonal psychology (Abrams, Chapter 21). All chapters provide a detailed analysis on how these different orientations may be used in GIM practice.

Frohne-Hagemann (Chapter 19), presents us with the basic concepts of mentalisation, and how GIM can be considered as one such intervention. Perilli (Chapter 20) examines the "specific role played by metaphor, emotion regulation and music in the process of therapeutic and growth oriented change

that takes place in the Bonny Method of GIM" (p. 355). The chapter is supported with both neuroscientific findings, empirical evidence, and case studies.

The transpersonal, psycho-spiritual, as well as the spiritual-transpersonal dimensions of BMGIM are presented in several chapters of the book, particularly by Greagh (Chapter 10), Abrams (Chapter 21), and Smith Goldberg (Chapter 26). Abrams calls for further consideration on the role of a theory of transpersonal BMGIM phenomena as "such a theory would address the unique synergy of the elements of BMGIM and how these, in turn inform the nature of transpersonal BMGIM experience" (p. 393).

Part Four of the book (Chapters 22-25) deals with GIM programs. Beginning with "A Historical Account of Music Programs in GIM", the reader explores the history of the predesigned music programs and follow the authors through all the changes of the music programming following the development of technology throughout the years.

Fuglestad (Chapter 23) presents us with a very interesting overview of new programs developed by GIM therapists in Europe, UK and South Africa (21 programs), which indicates the amount of work and commitment offered by our European colleagues through the years. The programs are of different working levels and some of them are specially designed only for "experienced therapists, colleagues and GIM trainees within a self-development-oriented context willing to expand their inner self" (p. 413). A short description for every program is offered.

Cultural dimensions of the GIM practice are also raised in different articles in this second edition of the book. Wai Ma Ng presents us with his "Chinese GIM Programs" (Chapter 24), developed to meet the special needs of his Chinese clients through therapeutically relating to their culture and heritage. Work based on the Yin-Yang principle, program analysis and the reflections of his clients are presented.

In Part Five of the book, "Research and Theory" (Chapters 26 to 31), we find Körlin's chapters on the Neuropsychological Theory of Traumatic Imagery (Chapter 27) and "Music Breathing" (Chapter 28). Körlin guides us through his Music Breathing technique, which was originally built to address traumatic stress by increasing the window of tolerance, the state where "we can hold and process thoughts, emotions (Siegel, 1999), and in the case of GIM, also images" (p. 534). There are also three very interesting chapters about GIM research. Grocke (Chapter 31) highlights the possibility of "discordance" between qualitative and quantitative data and suggests mixed methods of research as providing "an ideal structure for Bonny Method of GIM research" (p. 605).

In Part Six (Chapters 32-36), we find articles on professional issues including supervision and ethical practice. Sanfi's article, on the "Use of Technology in GIM Therapy" (Chapter 32), addresses several technological issues and gives a valuable overview, including descriptions and information on devices, software and technologies relevant to GIM practice. It introduces us to new possibilities and raises ethical issues relating to online sessions. This is of special interest to practitioners especially now due to the restrictions on in-person work due to the COVID-19 pandemic.

At the beginning of this review, I shared with you my impression of this book being a 'bible' for GIM practice. I believe this to be an updated edition that illustrates the challenging, yet evolutionary, growth of this method. It gathers together and reflects years of research, knowledge, experience and growth, and shows the passion of practitioners in the field of GIM. It is inspiring to see how GIM is being accepted and incorporated in different therapeutic settings and is bringing "the deeply felt

experience that music is healing and provide(s) us with the gift of reaching our inner worlds through the aesthetic carrier of music, carefully chosen and deeply received" (Clark, p. 24). As GIM practice continues to spread, we look forward and hope for an even more exciting era ahead for both research and practice.

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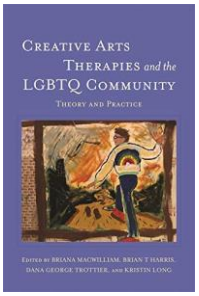
Approaches: An Interdisciplinary Journal of Music Therapy
15 (1) 2023

ISSN: 2459-3338 | www.approaches.gr

BOOK REVIEW

Creative arts therapies and the LGBTQ community: Theory and practice (Macwilliam, Harris, Trottier & Long, Eds.)



Reviewed by Christina Santaka
Independent scholar, The Netherlands

Title: Creative arts therapies and the LGBTQ community: Theory and practice **Editors:** Briana Macwilliam, Brian T. Harris, Dana George Trottier & Kristin Long **Publication year:** 2019 **Publisher:** Jessica Kingsley Publishers **Pages:** 304 **ISBN:** 978-1785927966

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Publication history:
Submitted 14 Feb 2021
Accepted 21 Feb 2021
First published 8 Mar 2021

The book *Creative Arts Therapies and the LGBTQ Community*, edited by Briana Macwilliam, Brian T. Harris, Dana George Trottier and Kristin Long, presents the experiences of 16 mental health professionals (psychanalysts, music therapists, art therapists and dance therapists) describing their work with the LGBTQ (lesbian, gay, bisexual, queer/questioning) community.

The stigmatisation and discrimination that the LGBTQ community may face can cause negative feelings that can lead to mental health issues, emotional discomfort, and negative self-image. As mentioned in the book, research conducted among art therapists has made apparent the lack of sufficient education in overcoming issues that occur during sessions with the people from the LGBTQ community. The main idea of the book is to expand the knowledge base and raise awareness on the subject for arts therapists who work with the LGBTQ community while aiming at a deeper understanding of the issues that this community might face. Overall, the authors and editors of the book have made a sufficient attempt in providing information on the subject, both through their professional experience with the LGBTQ community and via their personal experiences based on their sexual orientation.

The reader can find important information in each chapter of the book, such as various techniques from different approaches that have been used in sessions. Additionally, there are examples of specific obstacles and/or challenges that the therapists faced during sessions as well as questions for future development in order to enrich LGBTQ-related research. More specifically, in the beginning of each chapter the respective authors present the topic that they will focus on and in some cases they also disclose their sexual orientation. The authors explore the topic from a cultural perspective as well as from a more social lens, while expanding qualitative, quantitative and arts-based

research. As the book focuses on arts therapies interventions, it provides examples from the contributing therapists' sessions who work with the LGBTQ community. Given that there is a need for further research and awareness on the subject, the aforementioned case examples could be very valuable and useful for therapists who work with this specific community. Another strong point of the book is the presentation of excerpts from the authors' discussions in peer supervision. This can potentially help or even challenge the reader both professionally and personally by aiming at the deconstruction of social stereotypes leading to the non-stigmatisation of the LGBTQ community. Furthermore, the book invites each therapist to think of possible biases that may come up during sessions.

From my personal interest in this subject after conducting a literature review during my postgraduate music therapy studies (Santaka, 2017), I became aware that research in relation to the LGBTQ community is limited, especially in the music therapy field. This becomes apparent from chapter seven in the subsection *Music Therapy and LGBTQ Literature,* where the author and music therapist Brian T. Harris presents previous music therapy research studies. However, there was no reference on previous research from Chase (2004) who evaluated articles that referred specifically to gay individuals, providing an overview regarding therapeutic interventions and their application in music therapy. Similarly, an article from Antebi and Gilboa (2017) presented the relation between song composition and the coming out process. A review of the literature shows that older research from Lee (1996) and Bruscia (1998a, 1998b) presented the work of music therapists with gay clients with AIDS, providing a first glance on issues deriving from sexual orientation during sessions.

In this chapter, Harris begins with disclosing his sexual orientation touching, in my opinion, a very important matter related to the implications of the therapist's disclosure on the client. He then discusses briefly research on music therapy with the LGBTQ community to date and continues with referring to his own sexual orientation and how the latter has impacted both his professional and his personal life so far. This particular chapter intrigued me because of the discussion of potential challenges that therapists may face in their professional work deriving due to their sexual orientation. However, I find the flow of this chapter slightly interrupted due to the fact that the author initially describes the impact that the disclosure of the therapist's sexual orientation has on the clients. Then, the reader is taken to something more generic through the presentation of previous research regarding music therapy generally in relation to the LGBTQ community and eventually returns to the importance of the therapists disclosing their sexual orientation while presenting case examples from sessions. Perhaps this chapter would benefit more from a more continuous flow by presenting previous relevant literature on music therapy and the LGBTQ community at the beginning of the chapter instead of the middle. Then it could move on to the analysis of the concept of each person's identity and the meaning of sexual identity, and conclude with the interesting case examples from sessions that were presented at the end of the chapter.

Chapter eight *Seeking the Uncensored Self* written by music therapist Julie Lipon, offers a general picture regarding the therapeutic process with transgender clients. Lipon, drawing on her own work, describes the challenges that transgender individuals might face because as she also refers in the chapter, many individuals who self-identify as transgender have learnt from a very young age to dissociate body and mind. She also explores how lyrics discussion in groups raises questions concerning the authenticity of the self. She then employs referential improvisation, which is a

technique where the client demonstrates an idea, a feeling, an image or a story, and then encouraged to discuss in the sessions about their feelings and connect with their body.

A weak point of the book, as it was also discussed by the editors themselves, is that professionals who contributed in this book, even though they come from different cultural backgrounds, all live and work in New York. Consequently, all research that has been explored might lack geographical range as they all come from the United States. Similarly, the research studies presented in the fifth chapter *Attuning to the Needs of LGBTQ Youth* regarding the trauma that exists among LGBTQ adolescents refers only to individuals who live in USA.

Undeniably, the publication of this book constitutes a very important step towards a deeper understanding on a relatively underrepresented subject and could be perceived as one more step for further research. I would recommend this book to arts therapists who work with the LGBTQ community and to therapists/trainees who may wish to expand their knowledge on the arts therapies and the LGBTQ community. It would also be important to conduct research in other geographical regions as well with a variety of background therapeutic approaches. Research within the music therapy field would be beneficial for music therapists that work with LGBTQ individuals. Additional training programmes for arts therapists targeting issues deriving from sexual orientation, would be necessary in order to address obstacles that may arise in sessions.

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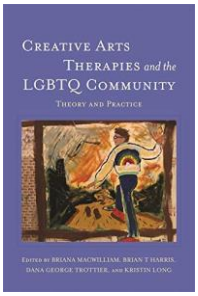
Approaches: Ένα Διεπιστημονικό Περιοδικό Μουσικοθεραπείας
15 (1) 2023

ISSN: 2459-3338 | www.approaches.gr

ΒΙΒΛΙΟΚΡΙΤΙΚΗ

Creative arts therapies and the LGBTQ community: Theory and practice (Macwilliam, Harris, Trottier & Long, Επιμ.)



Κριτική από τη Χριστίνα Σαντακά

Ανεξάρτητη επιστήμονας, Ολλανδία

Τίτλος: Creative arts therapies and the LGBTQ community: Theory and practice **Επιμελητές:** Briana Macwilliam, Brian T. Harris, Dana George Trottier & Kristin Long **Έτος δημοσίευσης:** 2019 **Εκδότης:** Jessica Kingsley Publishers **Σελίδες:** 304 **ISBN:** 978-1785927966

ΒΙΟΓΡΑΦΙΑ ΚΡΙΤΗ

Η **Χριστίνα Σαντακά** έχει εργαστεί ως μουσικοθεραπεύτρια στο Εδιμβούργο με άτομα με μαθησιακές και αναπτυξιακές δυσκολίες, αυτισμό και διαταραχές ψυχικής υγείας. Από τον Σεπτέμβριο του 2019 ζει στην Ολλανδία. [christina_santaka@aol.com]

Ιστορία δημοσίευσης:
Υποβολή 14 Ιουν. 2020
Αποδοχή 21 Ιαν. 2021
Δημοσίευση 8 Μαρ. 2021

Στο βιβλίο *Creative Arts Therapies and the LGBTQ Community*, που επιμελείται από τους Briana Macwilliam, Brian T. Harris, Dana George Trottier και Kristin Long, παρουσιάζονται εμπειρίες 16 επαγγελματιών υγείας (ψυχαναλυτές, μουσικοθεραπευτές, εικαστικοί θεραπευτές και χοροθεραπευτές) σχετικά με τη δουλειά τους με την κοινότητα Λεσβιών, Ομοφυλόφιλων, Αμφιφυλόφιλων, Τρανς, Κουήρ (ΛΟΑΤΚ)[1].

Η στιγματοποίηση και οι αρνητικές διακρίσεις που μπορεί να δεχτεί η ΛΟΑΤΚ κοινότητα ενδέχεται να προκαλέσουν αρνητικά συναισθήματα που ίσως οδηγήσουν σε ψυχικές διαταραχές, συναισθηματική δυσφορία και αρνητική εικόνα του εαυτού. Όπως αναφέρεται στο βιβλίο, μετά από έρευνες που έχουν γίνει με εικαστικούς θεραπευτές διαπιστώθηκε πως δεν υπάρχει επαρκής εκπαίδευση στην αντιμετώπιση προβλημάτων που πιθανόν να προκύψουν κατά τη διάρκεια των συνεδριών με ΛΟΑΤΚ άτομα. Η κεντρική ιδέα του βιβλίου είναι να διευρύνει τη γνώση και την ευαισθητοποίηση των θεραπευτών μέσω τέχνης που δουλεύουν με τη ΛΟΑΤΚ κοινότητα και να συμβάλει σε μια ίσως καλύτερη κατανόηση των προβλημάτων που αντιμετωπίζει η συγκεκριμένη κοινότητα. Σε γενικές γραμμές, οι συγγραφείς και επιμελητές του βιβλίου έχουν κάνει μια επαρκή απόπειρα απόδοσης πληροφοριών, τόσο μέσα από την επαγγελματική τους εμπειρία με τη ΛΟΑΤΚ κοινότητα, όσο και μέσα από προσωπικές τους εμπειρίες βασισμένοι στο σεξουαλικό τους προσανατολισμό.

Ο αναγνώστης μπορεί να βρει σημαντικές πληροφορίες σε κάθε ένα από τα κεφάλαια του βιβλίου, όπως για παράδειγμα τεχνικές που έχουν χρησιμοποιηθεί κατά τη διάρκεια συνεδριών. Επιπλέον, παρουσιάζονται συγκεκριμένα εμπόδια ή/και δυσκολίες που αντιμετώπισαν οι

[1] Το διεθνές αρκτικόλεξο είναι LGBTQ (Lesbian, Gay, Bisexual, Transgender and Queer or Questioning).

θεραπευτές κατά τη διάρκεια συνεδριών, καθώς και ερωτήματα για μελλοντική ανάπτυξη και επέκταση της έρευνας στη ΛΟΑΤΚ κοινότητα. Πιο συγκεκριμένα, στην αρχή κάθε κεφαλαίου οι εκάστοτε συγγραφείς παρουσιάζουν το θέμα που διαπραγματεύονται, αποκαλύπτοντας και τη δική τους σεξουαλική ταυτότητα ανά περιπτώσεις. Διερευνούν το θέμα τόσο από πολιτισμική, όσο και από μια ευρύτερη κοινωνική σκοπιά, επεκτείνοντας την ποιοτική και ποσοτική έρευνα, καθώς και τη βασισμένη στις τέχνες έρευνα. Καθώς το βιβλίο επικεντρώνεται σε θεραπευτικές παρεμβάσεις μέσω τεχνών, προσφέρει παραδείγματα από τις συνεδρίες των συνεισφερόντων θεραπευτών με τη ΛΟΑΤΚ κοινότητα. Δεδομένου ότι υπάρχει ανάγκη για περαιτέρω έρευνα και ευαισθητοποίηση πάνω στο θέμα, τα παραπάνω παραδείγματα από συνεδρίες μπορούν να είναι αρκετά πολύτιμα και χρήσιμα για θεραπευτές που δουλεύουν με τη συγκεκριμένη κοινότητα. Ακόμα ένα δυνατό σημείο του βιβλίου είναι η παρουσίαση παραδειγμάτων από συζητήσεις των θεραπευτών μέσα από τις εποπτείες με συναδέλφους. Αυτό ενδεχομένως μπορεί να βοηθήσει ή ακόμη και να προκαλέσει τον αναγνώστη τόσο επαγγελματικά όσο και προσωπικά, στοχεύοντας στην αποδόμηση κοινωνικών στερεοτύπων και πιθανά στη μη στιγματοποίηση της ΛΟΑΤΚ κοινότητας. Επιπλέον, το βιβλίο προσκαλεί τον κάθε θεραπευτή να σκεφτεί πιθανές προκαταλήψεις που ίσως υπάρξουν κατά τη διάρκεια θεραπειών.

Από προσωπικό ενδιαφέρον στο συγκεκριμένο θέμα μετά από βιβλιογραφική ανασκόπηση που πραγματοποίησα κατά τη διάρκεια των μεταπτυχιακών μου σπουδών στη μουσικοθεραπεία (Santaka, 2017), συνειδητοποίησα πως η έρευνα όσον αφορά τη ΛΟΑΤΚ κοινότητα είναι σχετικά περιορισμένη, ιδιαίτερα στο πεδίο της μουσικοθεραπείας. Αυτό φαίνεται και από το έβδομο κεφάλαιο στην υποενότητα *Music Therapy and LGBTQ Literature*, όπου ο συγγραφέας και μουσικοθεραπευτής Brian T. Harris παραθέτει προηγούμενες έρευνες στη μουσικοθεραπεία. Παρόλα αυτά, φαίνεται να μην έχει γίνει αναφορά σε έρευνες του Chase (2004), ο οποίος αξιολόγησε άρθρα που απευθύνονταν συγκεκριμένα σε ομοφυλόφιλα άτομα και παρείχε μια ανασκόπηση σχετικά με θεραπευτικές προσεγγίσεις και την περαιτέρω εφαρμογή τους στη μουσικοθεραπεία. Αντίστοιχα, άρθρο των Antebi και Gilboa (2017) παρουσιάζει τη σχέση μεταξύ της σύνθεσης τραγουδιών και της εκδήλωσης των σεξουαλικών προτιμήσεων (coming out). Από την ανασκόπηση της βιβλιογραφίας προκύπτει πως παλαιότερες αναφορές από τους Lee (1996) και Bruscia (1998α, 1998β) έθιξαν επίσης τη δουλειά μουσικοθεραπευτών με ομοφυλόφιλους που πάσχουν από AIDS, παρέχοντας μια πρώτη ματιά σε θέματα που αφορούν το σεξουαλικό προσανατολισμό μέσα στις συνεδρίες.

Σε αυτό το κεφάλαιο, ο Harris ξεκινάει αποκαλύπτοντας τη δική του σεξουαλική ταυτότητα, θίγοντας ένα πολύ σημαντικό κατά τη γνώμη μου θέμα, το οποίο αφορά στις επιπτώσεις που έχει η αποκάλυψη της σεξουαλικής ταυτότητας του θεραπευτή στον θεραπευόμενο. Στη συνέχεια παρουσιάζει περιληπτικά την έρευνα που έχει γίνει μέχρι στιγμής στη μουσικοθεραπεία με τη ΛΟΑΤΚ κοινότητα και συνεχίζει αναφερόμενος στη δική του σεξουαλική ταυτότητα και στο πώς έχει συμβάλει μέχρι τώρα τόσο στην προσωπική όσο και στην επαγγελματική του πορεία. Το συγκεκριμένο κεφάλαιο, μου προκάλεσε αρκετό ενδιαφέρον σχετικά με τις δυσκολίες των θεραπευτών που μπορεί να προκύψουν λόγω της σεξουαλικής τους ταυτότητας κατά τη διάρκεια της επαγγελματικής τους εμπειρίας. Παρόλα αυτά, βρήκα τη ροή του κεφαλαίου κάπως

συγκεχυμένη διότι ο συγγραφέας αρχικά, περιγράφει ένα συγκεκριμένο θέμα που έχει να κάνει με την αποκάλυψη της σεξουαλικής ταυτότητας των θεραπευτών στους θεραπευόμενους. Στη συνέχεια, ο αναγνώστης οδηγείται σε κάτι πιο γενικό, δηλαδή τη βιβλιογραφία που υπάρχει σχετικά με τη μουσικοθεραπεία γενικά στη ΛΟΑΤΚ κοινότητα και στη συνέχεια αναφέρεται ξανά στη σημασία της αποκάλυψης της σεξουαλικής ταυτότητας στις συνεδρίες παραθέτοντας και παραδείγματα από συνεδρίες. Ίσως αυτό το κεφάλαιο να επωφελούνταν από μια πιο συνεχόμενη ροή όπου προηγούμενες έρευνες στη μουσικοθεραπεία με τη ΛΟΑΤΚ κοινότητα θα μπορούσαν να αναφερθούν στην αρχή και όχι στη μέση του κεφαλαίου. Στη συνέχεια, θα μπορούσε να παρουσιαστεί η ανάλυση της έννοιας της ταυτότητας κάθε ατόμου και η σημασία της σεξουαλικής ταυτότητας, και να ολοκληρώσει με τα ενδιαφέροντα παραδείγματα από συνεδρίες που παρατίθενται στο τέλος του κεφαλαίου.

Το όγδοο κεφάλαιο *Seeking the Uncensored Self*, που είναι γραμμένο από τη μουσικοθεραπεύτρια Julie Lipon, προσφέρει μια γενικότερη εικόνα σχετικά με τη θεραπευτική διαδικασία με διεμφυλικούς (transgender) πελάτες. Η Lipon παρουσιάζει μέσα από τη δουλειά της τις δυσκολίες που αντιμετωπίζει η συγκεκριμένη κοινότητα, μιας και όπως αναφέρει η ίδια στο κεφάλαιο πολλοί άνθρωποι που αυτοπροσδιορίζονται ως τρανς έχουν μάθει να διαχωρίζουν το νου από το σώμα τους σε πολύ νεαρή ηλικία. Επιπρόσθετα, αναλύει το πώς η συζήτηση σε ομάδες για στίχους τραγουδιών εγείρει ερωτήματα σχετικά με την αυθεντικότητα του εαυτού. Στη συνέχεια, μέσα από τη χρήση αυτοσχεδιασμών όπου ο πελάτης απεικονίζει μια μη μουσική αναφορά όπως μια ιδέα, ένα συναίσθημα, μια εικόνα ή μια ιστορία (referential improvisation) ως τεχνική, ενθαρρύνει στις συνεδρίες της τους θεραπευόμενους να συζητήσουν για τα συναισθήματά τους και να συνδεθούν με το σώμα τους.

Ένα αδύναμο σημείο του βιβλίου, όπως αναφέρουν και οι ίδιοι οι επιμελητές, είναι ότι όλοι οι συνεισφέροντες, παρόλο που προέρχονται από διαφορετικά πολιτισμικά υπόβαθρα, ζουν και εργάζονται στην Νέα Υόρκη. Επομένως, πιθανά να μην υπάρχει γεωγραφικό εύρος στις έρευνες, καθώς όλες προέρχονται από τις Ηνωμένες Πολιτείες Αμερικής (ΗΠΑ). Παρομοίως, και οι έρευνες που παρουσιάζονται στο πέμπτο κεφάλαιο *Attuning to the Needs of LGBTQ Youth* σχετικά με το τραύμα που υπάρχει σε εφήβους της ΛΟΑΤΚ κοινότητας, αναφέρονται μόνο σε άτομα από τις ΗΠΑ.

Αναμφισβήτητα, η έκδοση αυτού του βιβλίου αποτελεί ένα πολύ σημαντικό βήμα προς τη βαθύτερη κατανόηση ενός σχετικά υποεκπροσωπούμενου θέματος και θα μπορούσε να συμβάλει στην προαγωγή περαιτέρω έρευνας. Θα πρότεινα το συγκεκριμένο βιβλίο σε θεραπευτές μέσω τεχνών που δουλεύουν με τη ΛΟΑΤΚ κοινότητα και σε θεραπευτές/σπουδαστές που ίσως θελήσουν να διευρύνουν τις γνώσεις τους πάνω στις θεραπείες μέσω τεχνών και τη ΛΟΑΤΚ κοινότητα. Θα ήταν επίσης σημαντικό να διεξαχθεί έρευνα και σε άλλες γεωγραφικές περιοχές καθώς και από ποικίλες θεραπευτικές προσεγγίσεις. Η έρευνα στον τομέα της μουσικοθεραπείας θα ήταν επωφελής για μουσικοθεραπευτές που εργάζονται με ΛΟΑΤΚ άτομα. Πρόσθετα εκπαιδευτικά προγράμματα για θεραπευτές μέσω τεχνών που στοχεύουν σε ζητήματα που προκύπτουν από το σεξουαλικό προσανατολισμό θα ήταν απαραίτητα για την αντιμετώπιση των εμποδίων που ίσως προκύπτουν κατά τη διάρκεια των συνεδριών.

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Approaches: An Interdisciplinary Journal of Music Therapy
15 (1) 2023

ISSN: 2459-3338 | www.approaches.gr

BOOK REVIEW

Music therapy in child welfare: Bridging provision, protection and participation (Krüger)

Reviewed by Joy Gravestock

Sheffield University, UK

Title: Music therapy in child welfare: Bridging provision, protection and participation **Author:** Viggo Krüger **Publication year:** 2020
Publisher: Barcelona Publishers **Pages:** 189 **ISBN:** 9781945411526

REVIEWER BIOGRAPHY

Joy Gravestock has an MA in psychoanalytic music therapy and is currently a PhD student at Sheffield University researching music therapy and attachment. She specialises in psychoanalytic, attachment based, relational music therapy for adoptees (with trauma experience), and their families. Her research and book with Jessica Kingsley Publishers explore relational repair from trauma effects occurring via micro-moments of attunement within an embodied musical therapeutic relationship. [joyfaith@joyandnickmusic.co.uk]

Publication history:
Submitted 21 Nov 2020
Accepted 25 Apr 2021
First published 14 Aug 2021

This book forms part of Krüger's research project "Toward an Independent Life in Community: A Qualitative Study of Music Therapeutic Practice in the Phase of Aftercare in Child Welfare" in Norwegian contexts, a collaboration between the GAMUT Grieg Academy's Centre for Music Therapy, the University of Bergen and Stendi AS. It would be of interest to music therapists wanting to learn about how music therapy helps in child protection, professionals working in the field with an interest in music therapy, academics/researchers in child welfare/protection and social work policy makers/practitioners .

Having recently written an adoption text for an international audience, I note the cultural specificity of what Krüger calls "child welfare" (similar to child protection in the UK). Like Krüger, in my current PhD work I try to find components of the work that are universal, with cross-cultural relevance. At times Krüger manages this, certain elements translate into an international context, but at others it feels context bound.

The concept of child welfare, for example, is unfamiliar in the UK where a child protection/safeguarding discourse dominates. Despite cultural difference, there are learning opportunities for UK music therapists to appreciate a less reactive, more preventative discourse. Krüger describes a role for music therapy in what I understand as a child protection discourse, and generalised childcare practice focussed on vulnerable children.

Working from a contemporary music therapy, resource-orientated, community situated collaborative practice, Krüger draws on Bruscia's (1998) 'Integral Thinking in Music Therapy.' Incorporating existing models, he moves beyond them by developing theory/practice relevant to this

client group. A philosophy permeates that music therapy should be a human rights-based enterprise aimed at "strengthening strong aspects, stimulating resources, individual interactions with culture and society, moving away from interventions to co-operation, seeing music therapy as a health resource" (p.167). His research addresses:

- A sociohistorical perspective.
- Notions of 'childhood' and 'welfare' as constructed entities.
- Links between the biological origins of music and its many sound uses.

Overall the text would have benefitted from some restructuring. The opening 25-page preface constitutes about one fifth of the text. This might have been better conceived as another chapter. The conclusion is scant, lacking any description about how the children Krüger writes about had integrated music therapy experiences into their lives and ongoing impacts this had.

Greater depth of exploration was required when referring to theorists beyond the music therapy profession. Krüger cites Marx and Hegel but such unfamiliar reading requires more grounding. Theorists such as Vygotsky and Lyotard are utilised to develop arguments without any context offered to their work. Postmodern thinking is addressed in just four lines. I wanted to see how Krüger utilises these theorists, in addition to more widely known music therapy theorists. More clarification of issues/concepts, for example the 'window of tolerance' (Siegel, 2015) was required. I would have liked Krüger to describe how he sees music therapy specifically enabling children to manage trauma effects.

Krüger introduced me to core concepts of the United Nations Convention on The Rights of the Child which function as a grand narrative overarching this music therapy practice. Here Krüger reaches beyond cultural specificity, as the UNCRC affects international music therapists as a metanarrative, from which national policies and practices emerge.

Attachment theory is weakly described, with Krüger mentioning Bowlby but not referencing the wealth of contemporary psychoanalytic attachment relational theorists. He states that children's rights activists criticise attachment theory; perhaps a context for such activism would have been helpful. Because children resist labels put upon them in a child welfare discourse, Krüger concludes that knowledge of attachment theory is not relevant to clients. I partially share this view having experienced adoptees resisting an 'attachment disorder' label. However, I disagree that attachment theory is an "over-the-heads" (p.59) discourse for clients. Theory can be made accessible to children, parents, carers, and sharing knowledge can empower.

Many child welfare clients had experienced trauma, and I felt Krüger's trauma definition was scant. Consequently when he later discusses music therapy as a "possible option for encouraging healthy brain development" (p.64), I wanted explanation of why this might be so. Brain plasticity is not mentioned, for example, as a reason why music therapists can be hopeful for change. Reference to how music specifically affects neurobiology would have been useful. An example is given of children who had difficulties with early development establishing reparative relationships with music therapists. How specifically this happened within music therapy was unclear.

Krüger states that "it is not particularly relevant to work through jazz […] and […] classical music" (p.650). This conclusion is unsubstantiated, assuming a generalised 'pop loving teenager.' In my own work with adoption trauma I have found, for example, Satie's "Gymnopodies" ostinato can provide a

felt sense of holding. A role for needs-led, free musical improvisations created collaboratively is not mentioned.

Krüger works with populations we would define as "at risk" in the UK, and probably on the Child Protection Register. My thinking was challenged about when it is appropriate to commence therapy. Psychoanalytically, it is usually thought children need environmental/familial stability in order to engage safely therapeutically. The music therapist entering at unstable junctures of life risks replicating other short, transitory relationships. Krüger highlights difficulties for the music therapist who may have to subscribe to a view that a child should come into state care, or remain at home, which would undoubtedly influence the therapy. Positives emerge however as Krüger states "music can be used to advocate for children and young people's voices to be heard within the context of their family experience" (p.79).

Norwegian "out of home" care described by Krüger translates in the UK as foster, residential, kinship and aftercare. Adoption is not included. This resonates least with the contemporary British care system and childcare plans such as foster-to-adopt/twin-tracking. As such, this was of interest academically, but lacked practical relevance. Krüger discusses supporting children through "relationships in transition," moving from one part of the child welfare system to another. Certainly, in the UK children move area in order for appropriate family finding and this can well mean losing their music therapist in the process.

Importantly Krüger addresses the impact that working with vulnerable children might have on the music therapist, describing what I would call complexities of the transference/counter-transference. Referencing Austin's (2010) work in vocal psychotherapy, examples from practice are provided which I understand as secondary traumatisation. There is no discussion of how supervision might mitigate against this. Krüger essentially recognises that "music therapy is not something we do to/with the child, it is also something we do with/to ourselves" (p.154). Both music therapist/client are affected in the music therapy relationship, and both may be changed by it.

Drawing on Arnstein's (1969) community work perspective, Krüger aims to offer a "participatory, collaborative, strengths-based music therapy […] listening to all voices […] engaging participants in collaborative processes of meaning making" (p.123). Discussion of power relationships suggests "facilitating equal relationships between the therapist and participant, where power is transferred from the expert to the person with the ability to empower themselves." How exactly this happens, when real differences between us and our clients exist, based within inevitable power relations, is unclear. Krüger states: "We can choose to emphasise peoples weaknesses and pathologies, or strengths and resources" (p.126). This positive framing can be helpful when working with families living under the weight of huge pathologising. However, these categories do not have to be positioned as binary opposites. Recognising and allowing for 'darker' material might offer a more authentic music therapy.

This was a positive book to read, wherein Krüger achieves his aim of centralising the child's rights as defined by the UNCRC. I was stimulated and challenged with regard to how this discourse informs practice. From a child protection perspective there was much to learn about working in challenging places. "Music therapists working in child welfare practices have the possibility to emphasise this multiplicity of childhood possibilities without losing sight of what has been labelled 'the best interests of the child'" (p.155).

The book is well referenced discussing multiple positions undergirding practice. Krüger illustrates his theoretical position throughout by the use of relevant case studies. However, deeper engagement with core concepts is sacrificed by giving scant reference to many. It contributes to the field a community music therapy approach to child welfare/protection, rooted in a metanarrative of the UNCRC .

A singular approach to the work, focussing on positives with less consideration of the lived impact of trauma is another limitation of the book. I query the wisdom of working with unsafe/unstable situations, but if this book was read alongside other music therapy texts on childhood trauma then balance may be achieved. Certainly the book excites me about future opportunities in the broader contexts of child welfare/protection practice.

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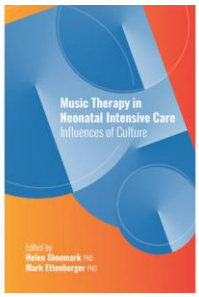
Approaches: An Interdisciplinary Journal of Music Therapy
15 (1) 2023

ISSN: 2459-3338 | www.approaches.gr

BOOK REVIEW

Music therapy in neonatal intensive care: Influences of culture (Shoemark & Ettenberger, Eds.)



Reviewed by Katie Rose M. Sanfilippo

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Title: Music therapy in neonatal intensive care: Influences of culture **Editors:** Helen Shoemark & Mark Ettenberger **Publication year:** 2020
Publisher: Barcelona Publishers **Pages:** 308 **ISBN:** 9781945411496

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Publication history:
Submitted 7 May 2021
Accepted 5 Jun 2021
First published 6 Jul 2021

Edited by Helen Shoemark and Mark Ettenberger, *Music Therapy in Neonatal Intensive Care: Influences of Culture,* takes the reader across various geographical areas to explore, using ecological systems theory (Bronfenbrenner, 1994), the role of culture within established and emerging music therapy programs within Neonatal Intensive Care Units (NICUs). This book is a collection of 14 chapters, 10 of which cover different cultural contexts within Europe (including German-speaking Europe, Italy, and Nordic countries), Australia, the United States (including Mid-Atlantic, Midwest, Southeast and Southwest regions) and South America (including Colombia and Brazil). The chapters are authored by a total of 26 expert music therapy researchers and clinicians working within each of these different cultural contexts. The editors state that the "purpose of the book is to explicate the issues of culture in real world settings where music therapy has become established in NICUs" (p. 4).

Throughout the book, Bronfenbrenner's (1994) ecological systems theory is used to discuss the influence of the chrono, macro, exo, meso and microsystem levels of culture on music therapy practice in neonatal intensive care. While some chapters draw on this ecological theory more consistently than others, the uniformity in the chapters' section structure helps the book feel coherent and assists the reader in exploring the differences and similarities in music therapy practice, programs, and the influence of culture across different countries and regions. Within the concluding chapter Shoemark and Ettenberger tie all the chapters together by highlighting some of the "common ecological threads" (p. 289) that elucidate the influences of culture on music therapy in the NICU.

Each chapter starts by considering the role that music generally plays within each context. This helps situate the reader within the musical culture of that country or region. The chapters then discuss how health care is organized and delivered within these different contexts and how this can influence music therapy within the NICU. Throughout the book, a distinction between countries and regions with socialized health care systems (Europe and Australia) and those with privatized systems (United States) is evident. The amenability of these different systems to include family members within the NICU and music therapy sessions is highlighted across the chapters and within the concluding chapter written by the editors. All chapters emphasise family-centred care (Gooding et al., 2011) as the current standard model within the NICUs the authors are working in. Even though this standard seems to be universal across all geographical regions discussed in the book, the way it is realised across these contexts is different. The influence of health care systems and differences between collectivist (e.g. Brazil and Colombia) and individualistic cultures (e.g. the United States) on the involvement of the family within infant care is considered within the concluding chapter. These distinctions in health systems and cultures illuminate most clearly the influence of culture on music therapy practice, such as what methods are used or developed in the NICU.

Finally, through the presentation of research, experience and case studies, each chapter discusses the music therapy services and programs established within the specific hospitals or country or region in which the authors work. They discuss the models of music therapy used within these specific settings, the potential outcomes, and give some specific examples of the way in which culture influences their music therapy practice and services. The music therapy models (e.g. First Sounds: Rhythm, breath and lullaby (Loewy et al., 2013) or creative music therapy (Haslbeck, 2014)) and methods used (e.g. improvisation or song writing) seem to apply across many of the cultural contexts. However, there is some inconsistency in how the evidence of the potential benefits of the models or methods is presented. Some chapters focus on the account of an author's specific experience within one context (e.g., Chapter 2: Establishing a Place for Music in the Italian NICU), while other chapters present a range of evidence (research and personal experience) which offers a more comprehensive overview of music therapy in neonatal intensive care within a specific country or region (e.g. Chapter 9: Music Therapy in the NICU in Columbia: An Overview of Current Practice and Development). Additionally, the amount of critical discussion around the role of culture varies across the chapters. A few chapters lack a comprehensive and critical presentation of research or a clear explanation of how culture has influenced their own personal practice or the music therapy programmes within their region. Nevertheless, overall, the authors are successful in describing the state of music therapy in neonatal intensive care within their countries or regions offering the reader a clear indication of the international reach and potential of music therapy in NICUs.

Preceding the concluding chapter, there are three chapters which discuss other aspects of culture and their influence on music therapy in NICUs. The first, by Helen Shoemark, describes how different types of NICUs (Paediatric versus Perinatal) impact music therapy research and practice. This chapter ends with a call for more research investigating a wider range of NICU settings and infants. As a researcher, not a clinician, there were other interesting areas of future research brought out in the discussions throughout the book which merit mention. First, is the difference in culture, experience and access between rural and urban areas, especially in the United States. Future work could investigate how music therapy practice and models used in urban areas might be better adapted

to the needs of families within rural communities. The role of siblings and grandparents as caregivers is also discussed within many of the chapters. Therefore, future research could investigate the role these family members might play in music therapy sessions within the NICU and the extent to which the surrounding culture facilitates their involvement. Finally, there is one continent, Africa, that was not mentioned at all within the book. Music therapy is practiced in South Africa (see Dos Santos 2005 for a discussion around the role of culture in music therapy in South Africa) and within many countries across Africa music plays a key role in traditional healing ceremonies (Vontress, 1991). Future work could explore the potential of music therapy, or music-based interventions more generally, for neonatal intensive care within different regions in Africa.

The second chapter in the book's final section is written by two male music therapists, John Mondanaro (USA) and Mark Ettenberger (Colombia). In this chapter they explore the role of fathers in the NICU through two case studies. The role of fathers is a significant area of interest in child development (Lamb et al., 1985) and perinatal mental health (Ramchandani et al., 2013). In fact, the changing role of the father has been investigated across cultures (e.g. Lamb, 1987). As suggested by the chapter authors, the influence of culture on the role of fathers within music therapy in the NICU is certainly a topic that could be developed further within future research.

The final chapter in this section, before the concluding chapter, provides helpful insights about the challenges of establishing new music therapy programs in NICUs and how to address them. This chapter draws upon the experiences of music therapists from Argentina, Israel, Japan, Poland, Spain, Taiwan and the United Kingdom and is applicable to music therapists thinking about starting a music therapy program or research study in their particular locale.

The book ends with a challenge to "resist the notion that music is one thing and to embrace all that it can be" (p. 301). However, to truly resist this notion, the book could have been further strengthened if it included more reference to research from other related disciplines or approaches, for example, music medicine, music psychology, or ethnomusicology (this was briefly done by the Vianna et al. in their chapter on Music Therapy and Culture in Brazilian Neonatal Units-Research and Clinical Practice). Moreover, a future edition of this book could benefit from the inclusion of additional voices such as other clinicians working within the NICU. I appreciated the forward from Professor Rod Hunt, a director of neonatal medicine, and believe that the inclusion of similar voices and experiences would ensure that this book draws a wider audience beyond music therapists, potentially allowing for the formation of more allies internationally. In fact, this addition would be in line with the last section of the book where the editors call for a more transdisciplinary approach towards music therapy programmes in NICUs. There has been some recent work looking at the challenges and opportunities gained from interdisciplinary collaboration and research (e.g. Choi & Pak, 2006; Tsiris et al., 2016) and more specific examples within the specific context of music therapy in neonatal intensive care could have been useful to include.

Overall, the structure of the book brings the reader on a journey across the world highlighting how the influence of different levels of culture are important to consider when implementing music therapy into neonatal intensive care. The book is an excellent addition to the wider conversation about the importance of culturally appropriate approaches to music therapy practice more generally (e.g. Stige, 2002; Whitehead-Pleaux & Tan, 2017). This book is a compelling and broad look into the connections and differences in music therapy for neonatal intensive care across cultures and has

useful practical advice for those, especially music therapists, who are looking to start or further develop music therapy programmes in NICUs within their communities.

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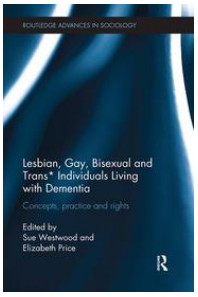
Approaches: An Interdisciplinary Journal of Music Therapy
15 (1) 2023

ISSN: 2459-3338 | www.approaches.gr

BOOK REVIEW

Lesbian, gay, bisexual and trans individuals living with dementia: Concepts, practice and rights (Westwood & Price, Eds.)



Reviewed by Vicky Guise

Independent scholar, UK

Title: Lesbian, gay, bisexual and trans individuals living with dementia: Concepts, practice and rights **Editors:** Sue Westwood & Elizabeth Price **Publication year:** 2018 **Publisher:** Routledge **Pages:** 241 **ISBN:** 978-1-138-34334-4

REVIEWER BIOGRAPHY

Vicky Guise is a music therapist and trained as a neurologic music therapist. Her experience includes working in mainstream schools, colleges, hospital settings and care homes. She has worked alongside young children in mainstream education, children with autistic spectrum conditions and people living with neurological conditions, including dementia and brain injury. Alongside a number of freelance projects, including an inpatient Aphasia Friendly Choir within a Stroke Rehabilitation Ward, Vicky works for Chroma and as a Mental Health Practitioner for the charity Place2Be. [victoriaguise@hotmail.co.uk]

Publication history:
Submitted 1 Jun 2021
Accepted 23 Jun 2021
First published 23 Aug 2021

Edited by Sue Westwood and Elizabeth Price, *Lesbian, Gay, Bisexual and Trans Individuals living with Dementia: Concepts, Practice and Rights* is one of the first collections that looks to invite professionals involved in dementia care to explore research and perspectives within this under-represented area. Within three main sections, a wide range of professions and research specialisms, including social work, gerontology and dementia studies, are brought together alongside the voices of those with lived experience. This provides a valuable, varied insight into current thinking around the intersection of theory and practice within dementia care, and how this relates to the LGBT community. I feel it is important to state that I approached reviewing this book from the position of an ally to the LGBT community and, although the arts therapies are not discussed specifically, found much that is relevant to the profession. As the editor states, the experience of care for LGBT people with dementia will "be informed by the readiness, or not, of services for people with dementia and those who care for them, to recognise, understand and be equipped to meet the needs of LGBT people" (p. 1).

The book is divided into three distinct sections, the first of which discusses different theoretical approaches to LGBT people living with dementia. This section felt particularly relevant to those developing dementia research and considering diversity within studies. Each of the four chapters in this section offers different perspectives to omissions of LGBT issues within dementia research and the absence of people living with dementia within LGBT research. Westwood provides an overview of the issues the absence of LGBT voices within dementia research has on equality of service provision. She also provides a useful and accessible exploration of gender, sexuality and gender identity and how

these can all impact experiences of care. A particularly impactful chapter from Hulko considers how an intersectional framework may provide opportunities to consider the identity of a person with dementia through different lenses such as gender, age, sexuality and social class. This suggests the need to consider all aspects of a person's identity. The potential for how this can support care is explored through a case study of woman who identifies as a trans, bi-sexual woman and how a dementia diagnosis could impact her experience of healthcare. In chapter 4, King et al. provide detailed explorations of how different theoretical approaches, including Queer theory can be applied to challenge heteronormative approaches to dementia research and care.

Section 2 consists of six chapters that explore different aspects of practice and support for LGBT people living with dementia. As a practitioner, this section was especially powerful and leaves the reader with much to consider around their approach to work and supporting diversity. The chapters from Hughes and Barrett et al. have similar over-arching messages that invite the reader to consider aspects of practice that may create barriers and challenges for LGBT people with dementia. This includes attitudes of staff to LGBT people, the understanding of diverse support networks within the LGBT community and the impact of LGBT history on healthcare. Gaining a much wider understanding of this context is invaluable to understand the challenges and fears people may face in accessing support. Witton goes on to extend this by exploring the specific challenges that are faced by transgender people living with dementia, where it is particularly emphasised how understanding the needs of the community is vital to provide appropriate care. However, very little research exists to establish fully what these needs are. Within these three chapters, there are many places where, as a reader, it feels as though music therapy could contribute to a more supportive care system for LGBT individuals. For instance, Witton states that "developing ways for the individual to have meaningful inclusion in their respective residential environment and developing trans-focused methods for life review and reminiscence" (p. 116) are critical to a person-centred approach to care for a trans individual. There is potential, for example, for music to act as a means to understand and build connections between residents in care settings by sharing music that is significant to their life story, composing new songs or using lyric substitution. Chapter 9 develops considerations around the needs of trans individuals in care with an exploration of the complexity of gender identity. A particularly helpful aspect of this chapter is the discussion around good practice guidelines that are currently being developed in the UK and USA, which provides an important starting point to reflect on inclusive practice and care. The specific individualised support needed for LGBT unpaid carers and the impact of one-day training LGBT awareness courses on care settings are discussed in the final chapters, which add to the message of the section that more understanding, research and safe spaces are needed within this area of healthcare.

The final section draws together issues of health care policy in different nations, including the US, Wales and Scotland and how this impacts the care of LGBT people living with dementia and their carers. Willis et al.'s chapter exploring the attitudes of care staff in Welsh care homes was particularly hard-hitting, with quotes included from staff that highlighted the lack of training and understanding of the needs of the LGBT community.

As a whole, Westwood and Price's edited collection shines a powerful light on an under-represented and marginalised issue. The inclusion of a range of professions and own-voice experiences make the discussion feel relevant to all who work within dementia care, whether as a

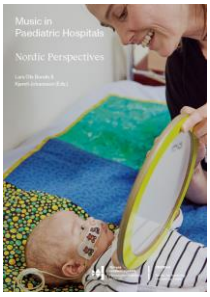
researcher or a practitioner. As a reader, this made the writing styles very varied, with some being more approachable from a practitioner perspective than others. Although the over-arching messages of a number of chapters felt similar, I was left inspired by the role music therapy could play in supporting these key concerns. As a person-centred profession, this collection encourages us all to consider our own understanding of issues for this community, how we can make our practices safe and supportive and how we can give these experiences a stronger voice in research.

Approaches: An Interdisciplinary Journal of Music Therapy
15 (1) 2023

ISSN: 2459-3338 | www.approaches.gr

BOOK REVIEW

Music in paediatric hospitals: Nordic perspectives (Bonde & Johansson, Eds.)



Reviewed by Marion Musting

Independent scholar, Estonia

Title: Music in paediatric hospitals: Nordic perspectives **Editors:** Lars Ole Bonde & Kjersti Johansson **Publication year:** 2021 **Publisher:** Norges musikkhøgskole **Pages:** 174 **ISBN:** 978-82-7853-287-4

REVIEWER BIOGRAPHY

Marion Musting, MSc**.** Born and raised in a small town of Southeast-Estonia, Marion received her Master's from the University of Tallinn. At the Keila Therapy Centre, she specialises in working with children and adolescents with various developmental challenges. She also supervises early childhood music groups' facilitation, and works to promote bonding between parents and young children. In 2017, her first album "Emalt lapsele" ("From Mother to Baby") released, which was inspired from her working enhancing bonding with mothers and her own experience of motherhood, as well. She has completed the First Sounds: Rhythm, Breath, Lullaby (RBL) NICU Training Tier 1 & 2. Since 2019 she has been providing music therapy service in the Department of Neonatal and Infant Medicine of Tallinn Children's Hospital. [marion@muusikaterapeut.ee]

Publication history:
Submitted 15 May 2021
Accepted 19 May 2021
First published 31 Aug 2021

Imagine if music was accessible to all mankind whether they were healthy or sick, and that promoting health through music was perceived as a valuable discipline integrated into every healthcare system. Unfortunately, despite music therapy in the context of paediatric care being a globally evolving area of practice, there are still countries where music therapy in paediatrics is not yet systematically integrated. As evident from the perspective of the Nordic countries (Sweden, Norway, Finland and Denmark), implementing music therapy in a medical setting can be challenging in various ways. It could be the lack of context-sensitive research evidence for the effectiveness of music therapy, as is the case with Estonia, my home country. Not having secure funding, which is often closely tied to proving the efficacy and "showing the value" of the work can also be an obstacle. Informing healthcare managers and gaining acceptance within the paediatric team is another challenge music therapists face.

Music in paediatric hospitals: Nordic perspectives gives an overview of the current state of music therapy practices in children's hospitals in the Nordic countries. Through exploring the work of practitioners and researchers, the book, which has seven chapters, explores the history of local music therapy practice in paediatric medical settings, the implementation of music therapy programs, and music therapy as valuable emotional support for the whole family.

Through the book, common themes and discussions related to the growth of the field are outlined by different authors: the importance of cultural sensitivity and multicultural aspects when implementing music therapy programs; the necessity for a relevant evidence base within the local

health care context; the relevance of raising awareness among healthcare managers and clinicians, and the need for music therapists to clearly communicate their work to healthcare professionals, patients and funders.

These issues are also very much present in Estonia. Although music therapy in paediatric hospitals is not entirely new in Estonia, the profession in the medical setting as a whole has not yet been established. One of the biggest issues is related to the local health care system where music therapy as a profession has not been recognised as part of the health insurance policy. The first attempts to introduce music therapy in this setting were made around 2012 in children and young peoples' psychiatric services. Over the years there have been individual music therapy posts in both the private and public sector, however, they have all been short-term (e.g. as part of dissertation research) and/or with external funding. In 2019 the first NICU music therapy program was initiated, again as a short-term project. It is clear though (as also reflected in this current book) that project-based work is time-limited and puts the growth and continuity of the field at risk. Evidently there is a strong need for a local research base for raising awareness of the field so that changes in health care contexts can be made and music therapists can be employed by hospitals.

In the first chapter the authors state that "models of practice are not directly transferable across cultural context and health care systems" (p. 8) and provide an important reminder for local practitioners to consider conducting context-sensitive local research in order to identify possible gaps music therapy can fill. The history of music therapy in Estonia is closely tied to that of Nordic practitioners and, I dare to believe, the Nordic countries and their models of practice are regarded as being worthy of emulation. This is understandable due to regional closeness as well as cultural similarities. While being currently the sole music therapist in Estonia working in the NICU music therapy field, I find this particular chapter to be especially close to my heart since there are many parallels to draw with the implementation of NICU music therapy in Sweden and Norway with that of Estonia. Similarly to the Nordic countries, Estonia has a long history of infant and Family-Centred Care (FCC) in neonatal units which brings its own opportunities and unique ways music therapy can play a part in supporting the whole family.

In the third chapter, cultural and multicultural aspects and their role in music therapy practice are discussed. In a world where societies have become more open and thus multicultural, this is a theme that cannot be overlooked. Although music is perceived as a universal language, cultural differences play their role when creating local music therapy programmes. In the same way, in Estonia a music therapist can experience challenges to take a multicultural approach when working in a medical setting. Multilingual environments can be quite complex when language barriers are considered. On the other hand, music as a non-verbal communication tool opens up wonderful opportunities for a music therapist to connect with the patient by providing sensitive and respectful attention to their culture and music. This aspect, to my mind, gives the music therapist the significant advantage of providing essential emotional support in a sensitive environment such as a hospital.

The following chapters explore how music therapy can provide procedural support, including pain-management and lowering patient and family anxiety. It is also recommended that having a clear documentation tool that is comprehensive for medical staff is crucial when communicating the work of a music therapist in a professional way. Music therapy as a procedural support is virtually an unknown in Estonia. The focus has been mostly on emotional support, and mood and mental

disorders. The Nordic experience certainly gives valuable insight into the possible research and practice areas for practitioners in other countries.

Ultimately, this book reflects the contributions Nordic practitioners have made locally in advocating music therapy in paediatric medical settings. The book provides valuable information for practitioners who work in countries where the music therapy profession has not yet been established in medical settings. But it also has great potential value for informing healthcare managers about music therapy as a vital complement to a more humanistic and family centered healthcare system. Hopefully the work that the Nordic countries have done gives a valuable reference for other countries, including Estonia, so that new music therapy positions can be created in the future.

Approaches: An Interdisciplinary Journal of Music Therapy
15 (1) 2023

ISSN: 2459-3338 | www.approaches.gr

CONFERENCE REPORT

The 10th Nordic Music Therapy Conference "Music therapy: Adapting approaches for health"

Henry Dunn
National Health Service, UK

CONFERENCE DETAILS

The 10th Nordic Music Therapy Conference
"Music therapy: Adapting approaches for health"
27-30 April 2022, Helsinki, Finland

AUTHOR BIOGRAPHY

Henry Dunn qualified as a music psychotherapist in 2002, and has worked for the National Health Service in the South West of England for 20 years. In this role he works as part of a creative therapy team with adults, individually and in groups, who have severe mental ill health, primarily due to trauma. In 2007, Henry set up the Autistic Spectrum Conditions Network for the British Association for Music Therapy, and in 2019 he was Chief Editor of the book *Music Therapy and Autism Across the Lifespan: A Spectrum of Approaches* (Jessica Kingsley Publishers). This showcased the variety of ways music therapy helps people on the autistic spectrum. Henry has presented at a variety of international conferences and delivers workshops and lectures. He lives in Exeter, UK, with his wife and three children. [jazzmanhenry@hotmail.co.uk]

Publication history:
Submitted 31 May 2022
Accepted 19 Aug 2022
First published 24 Oct 2022

INTRODUCTION

This conference, delayed from 2021 due to the pandemic and offered live and online, was the second part of what was billed as International Music Therapy Week, with the first half focusing on paediatric music therapy. Some presentations were co-delivered, with one or more people online. The hybrid event seemed to work well, and I'm not aware of any difficulties accessing the conference online. It is a positive that this enables more people to attend conferences.

NMTC 2022
HELSINKI, FINLAND

Photograph 1:
Conference logo

On the first evening, there was a symbolic handover from the previous host city to the other in the context of a concert. This contained a composition by music therapist Ilan Sanfi, performed by a youth orchestra from the West Uusima Music Institute. We were treated to a wonderful guided journey on a hot air balloon, after which we were invited to create images of the journey. Live music was a feature of the conference, with each morning starting with a brief performance by English six string fiddle player, Robbie Sherratt, and Estonian kannell player Eva Väljaots. It was such a joy to experience live music with other people after two years of these events not being possible.

As with all conferences, it would be hard to do justice to the depth and breadth of all the presentations. The plenary on the first morning consisted of a panel giving brief presentations about their current area of work and research. I found this format a little frustrating, as each presenter did not really have enough time to expand on their subject. On the other hand, it did give an opportunity to hear about more topics than would otherwise be the case.

Subjects included a comparison of music listening and music therapy in a psychiatric context. Using the Helping Alliance Questionnaire (Alexander & Lugorsky, 1986), Niels Hannibal demonstrated that music therapy promoted a stronger alliance and smaller drop-out rate than Music Listening. I enjoyed Kirsi Tuomi's discussion of taking an attachment-focused perspective on music therapy with adopted/fostered children and their families. This resonates with Gravestock's publication on the same subject (2021).

I did feel, though, that some presenters tried to cover too much in their allotted time. Claire Ghetti described using a socioecological model of music therapy, referring to McLeroy et al. (1988) and the World Health Organisation's social determinants of health (2022). She also described the LongSTEP (2021) clinical trial she is involved in, examining the effectiveness of music therapy with premature infants and their caregivers. They have been using the Post Partum Bonding Questionnaire (Brockington et al., 2001), and found it was an appropriate tool in this context. Covering these two subjects in a short presentation was quite ambitious; perhaps one topic would have enabled a deeper engagement with the material for the audience.

I was surprised that there was relatively little content in the conference on the topic of autism, traditionally a subject area that attracts many presentations. Monika Gerettseger did include it in her discussion, The MIDDEL project (Music Interventions for Dementia and Depression in Elderly Care), current developments in the Cochrane review for music therapy and autism, and rhythmic relating for autism (Daniel et al., 2022), but was I was not aware of many other papers on this topic. As this is a major area of work in the music therapy profession, I felt this to be something of an omission, and again wondered about the wisdom of overloading presentations with content.

Keynote speakers however had time to go into more depth in the presentations. One of these was on the theme of Music for Mood Disorders and Mental Health, with Jaakko Erkkilä examining two related randomised control trials (Erkkilä et al., 2011, 2021), analysing the efficacy of Integrative Improvisational Music Therapy with adults with depression, using microanalysis of various musical aspects. The research showed that improvisation could often lead to awareness of strong bodily and emotional sensations, as well as leading to clients verbalising about traumatic experiences for the first time. In addition to this, Erkkilä spoke about the use of other techniques such as Resonance Frequency Breathing (Courtney, 2022) and programmes of music to listen to at home as additional elements.

There were also keynotes, on the final day, by Teppo Särkämö and Wendy Magee, looking at the use of music and music therapy in the area of neurorehabilitation. This is an area that I am keen to learn more about as it is a very contemporary area of music therapy practice.

There was a very wide choice of presentations, and it was hard to know what to choose! Rather than trying to move between rooms to locate presentations I simply stayed in one space and decided to immerse myself in what was offered. Of particular note during one morning was a description of the work of Ai Nakatsuka with an orchestra in Sudan during a time of conflict. She described the importance of being there to bear witness, and quoted an adult participant saying "If it's only heard by

you, it's more than enough for me." The idea of bearing witness to our clients' experiences is one that resonates with me deeply.

The organisers are to be congratulated on putting together a wide variety of presenters and facilitators in a fantastic location, and with great hospitality. As always timetabling of sessions was difficult. I wondered if having longer presentations would be beneficial with short gaps between each one to facilitate movement between seminar rooms. There is, however, a skill in being able to speak about your work in a limited period of time. This certainly means that a wider variety of topics is available to conference attendees. There are also a range of formats for presentations. For example, I delivered a 90 minute-long workshop about a selection of different techniques for a range of creative therapies that music therapist could use in their sessions.

I am so pleased that I was able to attend this conference in person and experience live music-making with fellow music therapists as well as meet in person faces old and new after being sequestered away for so long. May this be the first of many hybrid conference opportunities to develop our profession; there are certainly many new areas of work that are being explored, moving our profession into the 21st century.

Correction notes: On 8th November 2022, this corrected version of the conference report was published. 'South Sudan' was corrected to 'Sudan' and the author clarified that the quote regarding the orchestra experience was by an adult participant.

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Approaches: An Interdisciplinary Journal of Music Therapy
15 (1) 2023

ISSN: 2459-3338 | www.approaches.gr

CONFERENCE REPORT

The 2nd International Symposium on Continuum Model of Guided Imagery and Music

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Music & Wellbeing, South Africa

CONFERENCE DETAILS

The 2nd International Symposium on Continuum Model of Guided Imagery and Music
23-24 October 2021, online

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Publication history:
Submitted 17 Jun 2022
Accepted 15 Aug 2022
First published 21 Oct 2022

The call for papers for *The 2nd International Symposium on Continuum Model of Guided Imagery and Music* suggested the following as a theme: Re-birth from the origin: Continuum model of GIM. The emailed invitation read as follows:

> The Continuum Model of Guided Imagery and Music (CMGIM) is growing worldwide with our collective inspiration and passion. The CMGIM is in a new stage of development with increased theoretical, research and practical depth. We invite you to join the 2nd symposium for the CMGIM to further expand our growth and knowledge through dialogues and discussion. The symposium will be an opportunity to reconnect, communicate and deepen our insights. (L. Summer et al., personal communication, 15 April 2021)[1]

[1] No conference webpage is available. Only delegates received the proceedings and recordings were made available for a short time only. The Korean Music Therapy Education Association website is: http://www.komtea.or.kr or: https://musictherapy.jams.or.kr/

CMGIM has developed naturally out of the Bonny Method of Guided Imagery and Music (BMGIM) (Summer, 2020). In the Bonny Method of GIM, a programme of specific, pre-selected classical music, mostly from the Western tradition, is used. Whilst listening, the client is guided by the therapist to experience images. The imagery can include symbols, sensations, memories, and/or feelings that are helpful for working through difficulties in a healing and transformative way (Bonny, 2001). MI uses only one piece of music, often the choice of the client's, which is repeated for a single-focused experience (Summer, 2020). CMGIM consists of these two methods of receptive music therapy, BMGIM and MI. Training in this model began in 2005, starting with the supportive MI level, through re-educative MI and reconstructive MI to supportive, re-educative and reconstructive GIM (Summer, 2020).

Although The Korean Music Therapy Education Association hosted the symposium, the initiative of the organising committee, which included people from both Western and Eastern countries, to host this symposium in English certainly broadened opportunities. The invitation early on in the symposium to ask questions in Chinese or Korean using the chat function, and it would be translated for all to understand, felt warm and welcoming. The 21 papers, six from Korea; nine from China; two each from the UK and the US; one from Germany; one with presenters from South Africa and Spain, and four spotlight sessions were offered over two days.

The first section focused on music, and Lisa Summer from the USA, developer of MI and the Continuum Model, appropriately opened the symposium with her spotlight, concentrating on *Reconnecting to our origins: learning from the 1970's Helen Bonny*. She used a cassette tape which contained music that Helen Bonny had recorded. Together with Lars Ole Bonde, Summer learnt how Bonny might have thought whilst putting this music together. They wondered if the two sides of the cassette represented one or two programmes, whether this was a draft or finished programmes, and whether it should be added to the existing BMGIM programmes. Through analysis of the tape, how the pieces of music were arranged and marked, and listening to the music, they realised the importance of the contour of the music. The contour of the music starts with vast possibilities, moving in a positive direction, building to a peak with possible catharsis. Then a time of rest is followed by another (possibly transcendental) peak, moving towards the return. Listening to Summer was like looking through Bonny's eyes to the importance of choosing music.

Other papers with music as the core element included that of Yang Wan (China) focusing on music listening, emotional regulation and song discussion. In Zhiyan Wang's (China) case report, the music created a bridge, filled the transitional space, to afford the client healing. Christine Routhier and Sally McKnight Harrison, both from USA and Martin Lawes (UK) respectively shared how we listen to music with our bodies, how the music we choose must be worthy of our clients and the work we do, and how a short extract of music could be useful.

In the presentation which I co-presented with Carmen Angulo and Isabel Solana, both from Spain, we looked at how music is collaboratively chosen by the client and therapist during a session. The importance of choosing the best music for the client at that particular moment was highlighted.

The second section of the symposium zoomed in on *research* and the spotlight was presented by Su Lin (China). Her topic: *Experiential supervision and self-growth of therapist in CMGIM training*. She used examples of supervision with experiential qualities and variations. In this process, the supervisor and supervisee explore the answers to questions together. Through using various techniques,

self-growth becomes part of the process for all parties involved. Something Su Lin mentioned that stayed with me, was that the therapist needs to enjoy growing in order to experience growth. This was a wonderful reminder that supervisors are there to support, and together with clinicians and trainees, they too grow during the process.

Varied research studies were presented, all from Eastern countries. Jieun Park's and Juri Yun's (both Korean) case studies respectively discussed self-worth and self-acceptance whilst Aimee Kim (Korea) explored experiences in groupwork. Mindfulness and CMGIM were investigated by Min Li (China) and Young Shil Kim (Korea). Two Q-method studies were presented by Guo Liu, Jing Xia and Xumei Wang (China). Zhonghua Sun's (China) research investigated MI and meta-cognition.

The focus of the second day of the symposium was on practice and Hyun Yu Chong (Korea) opened the day with a spotlight: *The concept of deepening and its strategies for expanding and enriching the inner experience in CMGIM supervision*. Deepening experiences are essential in MI work. She discussed various strategies to help therapists assist clients to explore and deepen their experiences through their imagery.

In the last spotlight presentation, Suzannah Scott-Moncrieff (UK) spoke in a sensitive yet convincing way about *The continuum model of GIM: An anti-oppressive framework*. She quoted Sue Baines's (2013) steps to get to this goal, by firstly taking action (e.g. dismantling oppressive systems, structures and therapy techniques), secondly by being self-reflective, starting with understanding one's own privilege and thirdly by being critical and asking important questions such as 'Who told me this'? Scott-Moncrieff's definition of the CMGIM summarises, in my opinion, in one sentence what this work is all about: "The continuum model of GIM systematises MI and GIM methods in a way that privileges *collaborative decision-making* and centres a person's *preferred music, safety and pleasure,* alongside their therapeutic needs and goals." She concluded by using an example of a session where the above-mentioned concepts, were clearly demonstrated, leaving the audience with an assurance that what was said about anti-oppressive therapy, could really be put into practice in CMGIM.

MI therapy and trauma was discussed in presentations by Cordula Dietrich (Germany) and Young Sook Kim (Korea), and MI work with children and adolescents were highlighted by Kyung Suk Kim (Korea), Chen Chen Wang (China) and Matina Karastatira (UK). Both Xin Zhao and Ying Wan presented practical music-centred projects in China during COVID-19, using music as a resource and for self-care.

I was privileged to be one of the first group of BMGIM-trained MI therapy trainees, the only South African trainee at that time. It was indeed gratifying for me to present at this conference with colleagues and to witness the vast range of people, countries, applications and research possibilities at this symposium. A heartfelt thank you to the organisers, and let us hope that next time, we can meet in person.

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ISSN 2459-3338