APPROACHES

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EDITORIAL

Expanding the scope of open access journals: The 'Approaches PLUS' initiative

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Queen Margaret University, UK; St Columba's Hospice Care, UK

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This new edition of *Approaches* contains a wealth of papers reflecting both the international and the interdisciplinary scope of the journal. Addressing different areas within music therapy and the broader field of musical care (Sanfilippo & Spiro, 2022), the articles encompass a clinical case study of music therapy with a child in Israel (Nir Seri) as well as original research studies regarding music-for-health practices in paediatric hospitals in the UK (Jessica Tomlinson and John Habron), the role of music listening in chronic pain and anxiety management (Marie Strand Skånland), as well as the lived experiences of six music therapists who identify as having hearing loss (Sara Cole and Catherine Warner). The theme of music listening and hearing loss is explored further through an interview with Paul Whittaker; a profoundly deaf musician whose work has been devoted to challenging assumptions regarding how people hear and perceive music, and encouraging other deaf people to engage with music.

At the 12th European Music Therapy Conference, *Approaches* took part in a roundtable discussion regarding the role that open access journals can, and perhaps should, play in decolonising music therapy. In discussion with colleagues from the editorial teams of the *Australian Journal of Music Therapy*, *Qualitative Inquiries in Music Therapy*, and *Voices: A World Forum for Music Therapy*, four key areas were identified: accessibility, language, power and diversity, and culture (Tsiris et al., 2022). Critical engagement with these areas is vital in our endeavours to disturb conventional assumptions around scholarly publishing.

In *Approaches*, our team has worked hard over the past year to expand the scope of what we offer. This work has led to the creation of 'Approaches PLUS,' a new space on the journal's website dedicated to the ongoing development and free dissemination of innovative resources. Building on our commitment to an open access culture, Approaches PLUS seeks to foster new forms of knowledge and knowing, and to reach diverse audiences.

Launching this new initiative, the first resource published in Approaches PLUS is an English-Greek music therapy dictionary. Its title, *Music Therapy Dictionary: A Place of Interdisciplinary Encounters*, reflects the dictionary's vision to create a co-constructed space where the Greek translation of

concepts and terms follows an informed process of documentation, rendering, and interpretation. Co-edited by Mitsi Akoyunoglou, Dimitra Papastavrou, Konstantina Katostari, and myself, the first edition of the dictionary contains over 1000 terms and acronyms, as well as 26 entries focusing in greater detail on specific concepts. Authored by 25 authors, these entries followed a peer-review process prior to publication. This process resonates with our work as a bilingual English-Greek journal seeking to promote the ongoing growth of the music therapy discourse in the Greek language in a culturally responsive and sensitive way.

The dictionary is intended to be a living resource which is updated regularly, inviting contributions from different authors. Potential authors can submit proposals for new entries as well as suggestions for alternative renditions and translations of terms which can be included in subsequent editions. The peer review process for all entries fosters a dialectical culture where behind-the-scenes translational dilemmas and debates can have direct implications for the advancement of terminology in music therapy.

In the coming months, Approaches PLUS will be enriched with other resources in addition to the dictionary. Common ground for all these resources is our vision for promoting new collaborative and community-led publishing approaches in music therapy where multiple voices and different languages are heard and represented. This ongoing development of *Approaches* is the fruit of teamwork founded in a social approach to leadership (Stodd, 2014) that is shared, creative, and empathetic (dos Santos, 2022). The recent appointment of Andeline dos Santos as co-editor-in-chief of *Approaches* feeds directly to the leadership of the journal. Andeline brings to this role a wealth of experience as a practitioner, educator, and researcher, and I very much look forward to working with her as a new chapter of *Approaches'* life begins!

REFERENCES

dos Santos, A. (2022). *Empathy pathways: A view from music therapy*. Springer.

Sanfilippo, K. R., & Spiro, N. (2022) Introduction. In N. Spiro & K. R. Sanfilippo (Eds.), *Collaborative insights: Interdisciplinary perspectives on musical care throughout the life course* (pp.1-11). Oxford University Press.

Stodd, J. (2014). *The social leadership handbook*. SeaSalt Learning.

Tsiris, G., Dos Santos, A., Coombes, E., Bolger, L., Eslava Mejía, J., Moonga, N., Ghetti, C., Hadley, S., Bibb, J., Keith, D., Banzon, G., Hales, G., & Redhead, C. (2022). Decolonising music therapy: What's the role of open access journals? *British Journal of Music Therapy*, Online Special Edition, 37. https://journals.sagepub.com/page/bjmb/abstractsofthe12theuropeanmusictherapyconference

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ΣΗΜΕΙΩΜΑ ΣΥΝΤΑΞΗΣ

Επεκτείνοντας το αντικείμενο των περιοδικών ανοικτής πρόσβασης: Η πρωτοβουλία «Approaches PLUS»

Γιώργος Τσίρης
Queen Margaret University & St Columba's Hospice Care, Ηνωμένο Βασίλειο

ΒΙΟΓΡΑΦΙΑ ΣΥΓΓΡΑΦΕΑ
Ο **Γιώργος Τσίρης**, PhD, είναι επίκουρος καθηγητής μουσικοθεραπείας στο Queen Margaret University και υπεύθυνος τεχνών στο St Columba's Hospice Care. Είναι συναρχισυντάκτης του Approaches. [gtsiris@qmu.ac.uk]

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Αυτή η νέα έκδοση του *Approaches* περιλαμβάνει μια σειρά δημοσιεύσεων που αντανακλούν τόσο το διεθνές όσο και το διεπιστημονικό εύρος του περιοδικού. Εξετάζοντας διαφορετικούς τομείς εντός της μουσικοθεραπείας, αλλά και του ευρύτερου πεδίου της μουσικής φροντίδας (Sanfilippo & Spiro, 2022), τα άρθρα περιλαμβάνουν μια κλινική περιπτωσιολογική μελέτη μουσικοθεραπείας με ένα παιδί στο Ισραήλ (Nir Seri) καθώς και πρωτότυπες ερευνητικές μελέτες σχετικά με τις πρακτικές μουσικής για την υγεία σε παιδιατρικά νοσοκομεία στο Ηνωμένο Βασίλειο (Jessica Tomlinson και John Habron), το ρόλο της μουσικής ακρόασης στη διαχείριση του χρόνιου πόνου και του άγχους (Marie Strand Skånland), καθώς και τις εμπειρίες έξι μουσικοθεραπευτών που αυτοπροσδιορίζονται ως άτομα με απώλεια ακοής (Sara Cole και Catherine Warner). Το ζήτημα της μουσικής ακρόασης και της απώλειας ακοής διερευνάται περαιτέρω από μια διαφορετική οπτική γωνία σε μια συνέντευξη με τον Paul Whittaker – έναν κωφό μουσικό με βαριά βαρηκοΐα το έργο του οποίου είναι αφιερωμένο στην αμφισβήτηση αντιλήψεων σχετικά με το πώς οι άνθρωποι ακούν και αντιλαμβάνονται τη μουσική, και στην ενθάρρυνση άλλων κωφών να ασχοληθούν με τη μουσική.

Στο 12ο Ευρωπαϊκό Συνέδριο Μουσικοθεραπείας, το *Approaches* συμμετείχε σε μια συζήτηση στρογγυλής τράπεζας αναφορικά με το ρόλο που μπορούν, και ίσως πρέπει, να διαδραματίσουν τα περιοδικά ανοικτής πρόσβασης στην προσπάθεια αποαποικιοποίησης της μουσικοθεραπείας. Σε συζήτηση με συναδέλφους από τις συντακτικές ομάδες των περιοδικών *Australian Journal of Music Therapy*, *Qualitative Inquiries in Music Therapy* και *Voices: A World Forum for Music Therapy*, εντοπίστηκαν τέσσερις βασικοί τομείς: προσβασιμότητα, γλώσσα, εξουσία και διαφορετικότητα και πολιτισμός (Tsiris et al., 2022). Η κριτική εμπλοκή με αυτούς τους τομείς είναι ζωτικής σημασίας στην προσπάθειά μας να διαταράξουμε συμβατικές παραδοχές που αφορούν τις επιστημονικές δημοσιεύσεις.

Στο *Approaches*, η ομάδα μας εργάστηκε σκληρά το περασμένο έτος ώστε να επεκτείνει το εύρος του τι προσφέρουμε. Η εργασία αυτή οδήγησε στη δημιουργία του «Approaches PLUS», ενός

νέου χώρου στην ιστοσελίδα του περιοδικού ο οποίος είναι αφιερωμένος στη συνεχή ανάπτυξη και δωρεάν διάδοση καινοτόμων υλικών. Στηριζόμενοι στη δέσμευσή μας για μια κουλτούρα ανοικτής πρόσβασης, το Approaches PLUS επιδιώκει να προωθήσει νέες μορφές γνώσης και τρόπων μάθησης, καθώς και να προσεγγίσει ποικίλα ακροατήρια.

Εγκαινιάζοντας αυτήν τη νέα πρωτοβουλία, το πρώτο υλικό που δημοσιεύεται στο Approaches PLUS είναι ένα αγγλοελληνικό λεξικό μουσικοθεραπείας. Ο τίτλος του, *Λεξικό Μουσικοθεραπείας: Τόπος Διεπιστημονικών Συναντήσεων*, αντικατοπτρίζει το όραμα του λεξικού να δημιουργήσει έναν συν-διαμορφωμένο τόπο όπου η ελληνική μετάφραση εννοιών και όρων ακολουθεί μια ενημερωμένη διαδικασία τεκμηρίωσης, απόδοσης και ερμηνείας. Σε συνεπιμέλεια της Μίτσυς Ακογιούνογλου, της Δήμητρας Παπασταύρου, της Κωνσταντίνας Κατοστάρη και εμού, η πρώτη έκδοση του λεξικού περιέχει πάνω από 1000 όρους και αρκτικόλεξα, καθώς και 26 λήμματα που εστιάζουν με μεγαλύτερη λεπτομέρεια σε συγκεκριμένες έννοιες. Τα λήμματα αυτά, τα οποία γράφτηκαν από 25 συγγραφείς, ακολούθησαν μια διαδικασία ομότιμης αξιολόγησης πριν από τη δημοσίευσή τους. Αυτή η διαδικασία συνάδει με το έργο μας ως δίγλωσσο, αγγλοελληνικό περιοδικό που επιδιώκει να προωθήσει τη συνεχή ανάπτυξη του μουσικοθεραπευτικού λόγου στην ελληνική γλώσσα με έναν πολιτισμικά ανταποκρινόμενο και ευαίσθητο τρόπο.

Το λεξικό αποβλέπει στο να αποτελεί μια ζωντανή πηγή που θα ενημερώνεται τακτικά, προσκαλώντας τη συνεισφορά διαφορετικών συγγραφέων. Οι ενδιαφερόμενοι συγγραφείς μπορούν να υποβάλουν προτάσεις για νέα λήμματα καθώς και προτάσεις για εναλλακτικές αποδόσεις και μεταφράσεις όρων που μπορούν να συμπεριληφθούν σε επόμενες εκδόσεις. Η διαδικασία ομότιμης αξιολόγησης που ακολουθείται για όλα τα λήμματα προάγει μια διαλεκτική κουλτούρα, εντός της οποίας τα μεταφραστικά διλήμματα και οι παρασκηνιακές συζητήσεις μπορούν να έχουν άμεσο αντίκτυπο στην εξέλιξη της ορολογίας στη μουσικοθεραπεία.

Τους επόμενους μήνες, το Approaches PLUS θα εμπλουτιστεί με περαιτέρω υλικό πέραν του λεξικού. Κοινός παρονομαστής για όλο το υλικό αποτελεί το όραμά μας για την προώθηση νέων συνεργατικών και κοινοτικά καθοδηγούμενων εκδοτικών προσεγγίσεων στη μουσικοθεραπεία, όπου πολλαπλές φωνές και διαφορετικές γλώσσες ακούγονται και εκπροσωπούνται. Αυτή η συνεχής ανάπτυξη του *Approaches* είναι ο καρπός ομαδικής εργασίας που βασίζεται σε μια κοινωνική προσέγγιση της ηγεσίας (Stodd, 2014), η οποία είναι κοινή, δημιουργική και ενσυναισθητική (dos Santos, 2022). Ο πρόσφατος διορισμός της Andeline dos Santos ως συναρχισυντάκτριας του *Approaches* τροφοδοτεί άμεσα την ηγεσία του περιοδικού. Η Andeline φέρνει σε αυτόν τον ρόλο μια πλούσια εμπειρία ως ασκούμενη επαγγελματίας, εκπαιδευτικός και ερευνήτρια, και αδημονώ να συνεργαστώ μαζί της καθώς ένα νέο κεφάλαιο στη ζωή του *Approaches* ξεκινά!

ΒΙΒΛΙΟΓΡΑΦΙΑ

dos Santos, A. (2022). *Empathy pathways: A view from music therapy*. Springer.

Sanfilippo, K. R., & Spiro, N. (2022) Introduction. In N. Spiro & K. R. Sanfilippo (Eds.), *Collaborative insights: Interdisciplinary perspectives on musical care throughout the life course* (pp.1-11). Oxford University Press.

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ARTICLE

A clinical case study: Music therapy for an Ultra-Orthodox child with behavioural difficulties and developmental gaps

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ABSTRACT
This study deals with Josh, a five-year-old Israeli child, within the Ultra-Orthodox community. Josh (pseudonym), was referred for music therapy for his non-age-compatible development and difficulties with emotional self-regulation. Josh's emotional-behavioural expressions were experienced as contradictory to Ultra-Orthodox socio-cultural conventions. Both Josh's family and community were reluctant to contain his difficulties. As a non-Ultra-Orthodox music therapist, the intercultural therapeutic process brought to light essential questions about my role in treating Josh. One such question was whether to help Josh reveal his genuine colourful character, contrary to conventions of his community or alternatively, help him cope with the demands of his conservative rigid community? During the therapeutic process, Josh's mother expressed difficulty in accepting his character, which I experienced as indicating a form of rejection. This experience appeared to leave Josh fearful of being abandoned by his mother and wishing for an attachment with someone who would understand and accept him. During sessions we played, improvised, sang and created an experience of togetherness. Subsequently, Josh felt himself at ease to express his colourful character. Thus, the child who began with an immature self-expression developed coherent regulated self-expression through voice, recordings, improvisations and communicative musicality. Therapeutic engagement that did not seek to "fix" him, but rather to contain and accept him, led Josh to adopt more effective behavioural, communicative, and emotional strategies that helped him to obtain emotional regulation. In conclusion, Josh became a child who managed to contain the intricacy of preserving his vivid character as well as accepting the Ultra-Orthodox community's conservative social conventions.

KEYWORDS
attachment,
emotion-regulation,
dysregulation,
Ultra-Orthodox,
developmental gaps,
intercultural,
self

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Dr Nir Seri is a musician and a music therapist with experience working with children from different cultural backgrounds in general and with Ultra-Orthodox children in particular. He also works with adults with special needs, and with children in a special education school. His musical composition and research deals especially with intercultural music. [seris42@gmail.com]

INTRODUCTION

As a music therapist, I have engaged in therapeutic processes with patients, some of whom have particularly touched me emotionally. A memorable child was a charming Israeli boy, aged five years, whom I shall call Josh. He was an Ultra-Orthodox boy, in terms of his Israeli intra-cultural affiliation.[1] The Israeli Ultra-Orthodox community includes Jewish people who are totally committed to the Jewish code of rules. They show general reluctance to be influenced by Western or modern ideologies in their way of life and dedicate their life to studying the holy Jewish scripts instead (Friedman, 1991; Friedman & Shelhav, 1985). The Ultra-Orthodox people live, in most cases, in separate neighbourhoods or even separate cities, as this enables them to comfortably maintain their conservative way of life (Seri & Gilboa, 2018). Living in such a community has unique consequences on its members, particularly the children. One of the most significant implications of being an Ultra-Orthodox child relates to self-concept. According to Yafeh (2004), Ultra-Orthodox children's self-concept is derived from their sense of communal affiliation. For instance, I have learned from my encounters with many Ultra-Orthodox children, that their answer to the question "who are you?" always contains their private name as well as their sub-communal affiliation. The Ultra-Orthodox community calls the individual to spiritually excel as well as to be saved from sin, and to constantly pursue moral improvement. The expectation is that the Ultra-Orthodox individual's most important ambition should be to fulfil his or her social assignment. Hence, the individual's self-realisation is intertwined with the realisation of his or her social role.

From the very beginning of the therapeutic process with Josh, I felt a profound bond with him. I was intrigued by his unusual character, which gave me the incentive to develop a deeper relationship with him. The therapeutic process was two-dimensional. Firstly, there was a developmental-emotional dimension, which reflected Josh's initial emotional status: His need for constant attention together with his infantile speech, and his disposition to lie on the floor. Also notable was his significant attachment to his mother, while she experienced difficulty in accepting him because of his difficulties. The second, was the family-social dimension,[2] which reflected Josh's energies and other differences that were perceived by his family, let alone by his Ultra-Orthodox community, to be incompatible with the conservative atmosphere of the environment in which he lived.

The therapeutic process also confronted me with a fundamental dilemma about the perception of my role in treating Josh: Who was this patient? Was it my job to change a child to better conform

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[1] The Israeli intra-cultural fabric contains a diversity of groups, which are different mainly in their interpretation of the relationships between the religious commitment to the Jewish commandments and the national commitment to the Israeli democratic regime, which in some cases seem to be contradictory (Sheleg, 2000). I will describe the three main ones (Yona & Goodman, 2004). The first is the secular group, which refers to Israeli-Jewish citizens who do not feel religiously committed but do feel a sense of honour to the Jewish commandments and experience a national commitment to the State of Israel (e.g. they serve in the IDF and celebrate the Israeli Independence day). The second is the national-religious group, which refers to Israeli-Jewish citizens who experience both religious commitment to the Jewish commandments and national commitment to the State of Israel (e.g. they serve in the IDF, celebrate the Israeli Independence day and engage in special prayer dedicated to the Israeli government). The third is the Ultra-Orthodox group, which refers to Israeli-Jewish citizens who are totally committed to Jewish commandments. They demonstrate reluctance to integrate into the entire Israeli society (e.g. they resist serving in the army as well as taking part in the Independence Day celebrations), holding the perception that the Israeli government should be established on the Jewish book of commandments, rather than the current democratic regime.

[2] In this case, the Ultra-Orthodox family is the community on a small scale. Namely, the family represents the communal values and voices.

with the expectations of a conservative Ultra-Orthodox community? Alternatively, should I help him recognise and cope with the gaps between his vivid character and the conservative perception of his community, that were probably not going to be lessened? Through this case study, we can learn not only about Josh's personal story but gain insights about the experiences of people living within the Ultra-Orthodox community more generally, particularly with regards to the confrontation between the desire to authentically be who one wishes to be and the obligation of obeying a higher religious authority, which seeks control of behaviour and broadly affects one's way of life.

BACKGROUND

Josh, attended an Ultra-Orthodox preschool. We met for music therapy sessions once a week within a Child Developmental Centre in a central city in Israel. Josh's mother worked as a manager of an afterschool child-care facility and his father assisted with the financial management within the same organisation. Josh was the second of four children in his family. His mother defined Josh's relationships with his siblings as complex. The elder brother would hurt him and he would annoy his sister. His infant brother (aged one) would cry out of apprehension whenever Josh would approach to pick him up. There was a suspicion that Josh's sister suffered from Celiac disease. Unfortunately, in the seventh month of her pregnancy with Josh, his mother contracted Cytomegalovirus (CMV). She described his birth as "normal but difficult and painful" and his developmental stages (walking, crawling, and speaking) as normal. The only difficulty she mentioned was his lack of sensory sensitivity. She described this as follows: "He has to touch [something] hard in order to feel." In his report on activities of daily living (ADL), Josh was assessed as: "Dependent and begging for help, clumsy, recently toilet trained but still has accidents".

At the age of four years, Josh was referred to an occupational therapist, due to difficulty in sensory regulation and his need for strong tactile stimulation. The occupational therapist described him as having

> [...] good age-matched abilities in the field of visual-motor perception, painting, and cutting. However, according to sensory analysis, difficulties in sensory regulation were found. Josh attains much enjoyment from vestibular and motor stimulation, is always looking for a feeling, including searching for an oral sensation. A treatment was begun in order to adjust to a sensory diet, but at its implementation, the treatment was discontinued owing to the mother giving birth.

The decision to refer Josh to music therapy was not made as a result of a medical recommendation but was taken independently by his parents. On the written intake questionnaire, Josh's mother defined the reason for his referral as follows:

> Because of his very infantile behaviour at home, frequent crying and insulting behaviour towards me; not listening and refusing to obey the word 'no', lying on the floor using babyish talk. He is a disgruntled child, wanting much attention, and whose moods can change in seconds. He goes wild, drops to the floor, gets

> dirty from everything and is prone to break things. Additionally, I was informed that his kindergarten teacher described him as 'a child who can cry for two whole hours because he was hurt by something or did not get what he wanted.' At home, he tends to lie down on the floor, often nagging: 'Bring me a drink; I want you to come' and so on… It is hard for him to do what is requested of him. He often lies on the floor, kicking, throwing objects and crying about petty things that are not appropriate for his age.

The description of Josh's behaviour and his repetitive choosing of ineffective strategies (Marik & Stegemann, 2016), i.e. changing moods, nagging, lying on the floor and kicking, paints a picture of emotional dysregulation. Emotional regulation "refers to the processes by which individuals influence which emotions they have, when they have them, and how they experience and express these emotions" (Gross, 2014, p. 6). The development of emotional regulation is influenced by external and internal regulatory processes. Internal processes refer to the development and maturation processes of a child's cognitive, sensory, and neurophysiological systems. External processes refer to interactional and social factors, with an emphasis on the importance of parental functioning for the development of emotional regulation. In other words, this is an effect of parent-infant dyadic interaction (Fink-Kronenberg, 2007; Fosha, 2001). In situations where, for various reasons, normal emotional regulation may not be achieved, this poses a risk for subsequent deficient cognitive and social development (Degangi et al., 2000; Music, 2014; NICHD, 2004).

As mentioned previously, the parents' decision for referring Josh to music therapy was taken independently.[3] In addition, as they were affiliated to an Ultra-Orthodox intellectual sub-group, they were not necessarily music-oriented. [4] Music has a significant role in emotion regulation, and music listening has been found to be an effective tool to arouse emotions (Bodner et al., 2007). Everyday music listening (Skanland, 2013), as well as Mindful Music Listening (Eckhardt & Dinsmore, 2012) has been found to hold potential for contributing to emotional regulation. Moreover, studies with adults suggest that listening to relaxing music promotes more adaptive emotional regulation as part of coping with an acutely stressful event (de la Torre-Luque et al., 2017; Thoma et al., 2013).

After describing his dysregulated behaviour, Josh's mother then explained his strengths as follows: Josh is "a strong boy, who struggles and vanquishes [sic] his big brother[5], generously agrees to share his possessions, eats without arguments, and knows how to join in, play and laugh". With his

[3] Creative Art Therapies – as a therapeutic discipline – is quite new for the Ultra-Orthodox community. It has been increasingly developed and has penetrated the Ultra-Orthodox environment over the last ten years (The Ultra-Orthodox Forum for Arts Therapists, n.d; Seri, 2013). Hence, I have experienced awareness gradually increasing of the differences between the variety of creative art therapies by Ultra-Orthodox case managers, as well as parents who refer to the Ultra-Orthodox Child-Development-Centers. Thus, a parent who sought therapy for his or her child, could be referred either to music or to art therapy, subject to availability.

[4] The Ultra-Orthodox community is sub-divided into many groups. One of them is the "Lithuanian Group" which refers to Ultra-Orthodox people who live or study according to the teachings and practices of the Lithuanian Jewish academies, which entails a more intellectual and analytical attitude, and minimizing that which is considered emotional in daily life (Friedman & Shelhav, 1985). It follows that the place of music in the daily life of this group – as potentially evoking emotional experiences - is considered less important (Seri, 2013). Josh's family was affiliated with the Lithuanian group. Hence his parents were less music-oriented when they sought therapy for him.

[5] By this she referred to his courage and determination.

friends she sees him as a leader, a tall boy who is strong for his age and speaks loudly. As far as Josh's mother is concerned, his difficulties began from the moment of birth, and they are more disturbing to the family than they are to Josh himself. Her expectations for the therapeutic process were that "the child will become reasonable, mature and empowered, controlling himself and concentrating quietly on a game that he plays by himself or with a friend. I don't want to see him crying unnecessarily so that he will become a happy and relaxed child who is pleasant to be with." The mother's detailed expectations reflected the social attitude of the Ultra-Orthodox community towards children. Her use of the word "reasonable" in relation to her 5-year-old child thoroughly fits the Ultra-Orthodox perception of the child as a "micro-adult", who is expected to integrate into the community, to absorb its values and to join its activities, either actively or passively (Seri, 2013).

In addition to the written questionnaire, an intake meeting was held. At this meeting, Josh was described by his mother as a very sensitive child who appeared to be upset "by every little thing". At this point I noticed my own feelings of being overwhelmed as a response to the emotional intensity of the problem as experienced by the mother. I felt that we were talking about a child who was showing his capacities, yet, within his immediate family environment these capacities were not being recognised as strengths and potential, but were rather seen as problematic and disruptive. Hence, I experienced this intake meeting as a difficult and dissonant engagement. Josh's mother's speech and body language conveyed great frustration and distress. It was apparent that she did not understand him, and had difficulty in relating to his capacities, which were expressed in a non-regulated manner and, as a result, she experienced difficulties in communicating with him. Josh's father was not present at the meeting. Josh's mother described him as a very busy man.

Josh's story can be explored in two integrated components: The first being his cultural characteristics and social conventions, which inevitably penetrated the session and affected the therapeutic process; the second being the clinical issue for which he was brought to music therapy. Working in a culturally-sensitive manner with the intricacy of such an integration relies on the therapist's ability to reflexively contemplate and comprehend the relationship between the two components, examining their relative weight and deciding which component may be core at a particular time in the process. In addition, the therapist has to understand the mutual influence of the cultural narrative (which presents a child who has an inappropriately vivid character that does not fit within the social conventions of his community), and the clinical narrative (which presents a child who has an objective, diagnosed difficulty and also a valued, colourful character). In Josh's case, both components were intertwined, with reciprocal influence. The clinical attitude regarding his developmental gaps, stemmed from reading the occupational therapy diagnosis which indicated a sensorial-tactile difficulty, as well as reading the mother's reports of his emotional difficulty. It also stemmed from my assessment of him which confirmed emotional-sensory difficulty and objective developmental gaps. Concerning the cultural issues, I listened to the mother's reports, as well as the terminology that she used to express the family's difficulty and distress, her description of facing the community and its demands, and her experience regarding Josh's emotional-sensory difficulty and his objective developmental gaps.

MUSIC THERAPY WITH ULTRA-ORTHODOX CHILDREN

In relation to psychotherapeutic treatments in the Ultra-Orthodox community, the research literature is quite fertile (Bruchin, 2014; Hess & Pitariu, 2011; Hoffman & Ben-Shalom, 2001; Huppert et al., 2007; Schnall, 2006), in contrast to music therapy in the Ultra-Orthodox community which has insufficiently explored. However, several important factors have been noted in distinguishing the uniqueness of music therapy with Ultra-Orthodox children, compared to music therapy with other populations (Seri, 2013):

1. Music is a highly significant component of Ultra-Orthodox children's daily lives.
2. The musical content of the therapeutic session is frequently affected by the communal agenda. Hence, the music therapist's role is to pay attention to communal events that may emotionally influence the patient.
3. Within the context of cross-cultural treatment (here between an Ultra-Orthodox patient and a non-Ultra-Orthodox therapist) the child often experiences the therapist's chanting as a profound reaching out. [6]
4. Ultra-Orthodox children accept music as part of their daily cultural experiences, e.g. at weddings, Jewish holidays or Shabbat family gatherings. Therefore, the music therapist should be aware of his or her potential choice of song, which the children will experience as being bound in their communal, cultural and personal experiences. For instance, as weddings are considered to be exciting and significant experiences for Ultra-Orthodox children, singing a wedding song with Ultra-Orthodox children can create a vitalising moment, in which they feel the association with a real wedding experience.
5. Ultra-Orthodox songs have an aura of holiness and are usually kept in their original structure. However, in the therapeutic environment these can be paraphrased for the sake of therapeutic goals. For example, a holy wedding melody can be used as a metaphor by the patient to depict bonding with his mother.
6. A better understanding of the role of music in Ultra-Orthodox children's daily life might broaden the therapist's empathy towards the Ultra-Orthodox parent's educational challenges. For instance, the behaviour of an overly enthusiastic child, who may yell and shout at home or school, might be experienced as inappropriate in relation to the volume levels that are valued within the Ultra-Orthodox community. The therapist's role is not only to contain the child's volume of expression but also to be acquainted with the volume deemed appropriate by his parents, family and community (Seri, 2013).

THERAPEUTIC PROCESS

The music therapy process with Josh included 30 weekly sessions of 45 minutes each. This structure was predetermined.

[6] The singing should be adjusted in terms of language, accent, terminology and familiarity with the repertoire.

Sessions 1-7: My acquaintance with Josh

Josh walked in with his mother and left her without difficulty. I saw a blonde boy with big, round, blue eyes, smiling but silent. After I told him what our music therapy sessions would entail, he chose the drums and played them hesitantly.

My initial acquaintance with a boy who was bigger than I expected for his age, and whose body language conveyed a sense of power, made me anticipate that his choice of drum would lead to loud banging (forte-fortissimo). In fact, the resultant sound was quiet (piano). In that moment I felt a sense of confusion. His body organisation was not compatible with his chronological age, i.e., he often lay on the floor or lay on the beanbag chair, sucking it.

Josh voiced a desire to play games, such as "I played the drum, now I want to play ball". Just like a parent watching a baby, he needed to be seen by me while he played. Sometimes he wanted to listen to music and I played him calming, quiet music depicting the sound of the sea.

He responded to my playing on the ocean drum by leaning over the beanbag chair, jumping on it with much pleasure, like a toddler. At other times, in trying to adjust a sound to his movement, I accompanied his running towards the beanbag chair by calling out, "Haaaaaa-boom!" Also, I spoke to him in a style of "parentese", which is the term for the infantile intonation used when speaking to babies (Ghazban, 2013).

When he arrived for the fourth session I sang "Hello," and he responded by saying that he wanted to play the guitar. I gave him the guitar, but he went to the piano. As I joined him, he disapproved: "But I hear you!" I then realised that he wanted me to simply listen to him rather than accompanying him musically. From that moment on, he was playing, and I was watching him. His choice to "wallow" in the beanbag chair continued. He asked me to watch and listen to him as he was racing to the beanbag chair or when he was playing the drums.

Since I had hardly met such a complex child before, I was both confused and amazed at the way Josh simultaneously exhibited three or even four different developmental levels. His chronological age was five years. He functioned at the developmental age of a six-year-old with regards to his body structure. His use of his voice reflected that of a child aged three years. He had no emotional ability to take an interest in anyone other than himself when I tried to engage him in a mutual activity. He also shifted to expressing features of the developmental age of a one-year-old with regards to his emotional level, as shown through his wallowing on the beanbag chair, his vocalisations as well as his tendency to lie on the floor. He mostly used vocal sounds rather than words when he wanted to express dissatisfaction or opposition. Later, I began to realise that his cognitive abilities were high for his age. However, I decided to concentrate on the emotional level (i.e. his emotional age) as I found this to be the core component of the process and a point of connection to his authentic self.

My acquaintance with Josh: Analysis

In Winnicott's terms, Josh's "self" seemed to be at a similar stage to the infant's early "moment of illusion" (Winnicott, 1958, p. 152) regarding his benign omnipotence (Jemstedt, 2019). According to Winnicott, during this stage the baby is unable to see that he or she is surrounded by a separate, external reality, containing many things that are "Not Me". The environment that represents the "not Me," presents contrasts to the growing infant, who experiences a gradual process that prepares him

or her to be able to merge his or her subjective world with the outside world and learn to distinguish between "Me" and "Not Me" (Yehuda, 2005). When I tried to join in with him and Josh said, "But I hear you," he may have been asking me to serve as a mother figure. I was there, with regard to Josh, as a "Subjective Object". [7] In light of Winnicott's (1995) conceptualisation, I experienced a dynamic state where I was both the object that the child had the capacity to reveal, and a separated entity who was waiting to be revealed. Thus, an intersubjective relationship, entailing a conscious desire to share experiences of events and things as Trevarthen and Hubley (1978) define it, had not yet evolved between Josh and I.

Concerning the music in the sessions, I made use of several therapeutic techniques and principles, to emotionally attune to Josh's presence: (1) Parental intonation ("parentese") [8] as a way of speaking to Josh; (2) a cross-modal technique of matching my sound to his movement; (3) listening to the experience being conveyed from him, including the expression of his power and agency; and (4) the desire to experience him emotionally rather than cognitively, which was most appropriate at this stage because of his immature emotional age (of about one year).

During our meetings, I found it very important to bracket my own inner assumptions related to Josh's intellectual age, chronological age, and body size as I found these to be distracting. I listened mainly to the "forms of vitality" (Stern, 2005) that Josh conveyed to me. For example, in my session notes, I used the words "storm", "remission", "restraint", "cuddling", in order to describe various activities that Josh engaged in. The beanbag chair served as Josh's safe place. That is where he would constantly return, and, even if he left it, he would eventually go back and play there for most of the session. In my opinion, the therapeutic process with Josh required me to regulate the intensity of my engagement according to his capability of containing me as a separate entity in the session while, in Winnicott's (1995) terms, I was waiting to be revealed.

Sessions 8-12: A beginning of "self"

Returning to session eight from a week's vacation I noticed that something had matured in Josh's mind. He began to be more expressive. This was now the beginning of the school year. Josh was able to coherently retell a story that his kindergarten teacher had narrated to him and his classmates. Josh was now demonstrating his ability to think of the other. In relation to his musical development, he was now able to understand musical tension and relaxation.

Additionally, Josh demonstrated his need for counting the remaining minutes until the end of each session. About twenty minutes before the end of a session, Josh would ask how much time remained. With repetitive requests, we turned this into a game. We would stand at the window overlooking the playground, thinking together about Josh's plans and where he was going to play after our session.

[7] Namely, an object that is created (in a subjective manner) by the infant, in his or her mind.

[8] "Parentese" (also referred to as Infant-Directed (ID) speech or "babytalk") is a unique way of communicating to infants. This form of communication contains heightened pitch, exaggerated pitch contour, increased rhythmicity and greater emotionality (Ghazban, 2013; Malloch, 2000).

All of these interactions contributed to the creation of an intersubjective relationship between us, which was reflected in a very intimate moment within one significant session. Josh shared his feelings with me of how much he loved his mother. Through his sharing and mutual playing a budding "self" had begun to bring itself to expression. Nonetheless, despite this emotional development, as well as the musical facilities in the room (i.e. musical instruments, a computer with a recording software, etc.), at this point in time music was not playing a significant part in his therapy.

The first encounter with Josh's parents within the therapeutic process

I met with Josh's parents once a month as part of the therapeutic process. Previously, at the intake meeting, only Josh's mother had come. During this meeting, she kept expressing tremendous difficulty in coping with Josh and his behaviour. Her body language, intonation, and the content of her language conveyed to me a lack of acceptance of Josh, almost to the point of rejection. According to Belsky (1984), parenting approach is one of the factors that influences the quality of dyadic interaction. A sensitive parenting approach contributes to the development of emotional regulation and to the transition from mutual regulation (which is typical for infants at a younger age) to self-regulation. In contrast, infants of non-sensitive mothers, experience higher levels of negative emotions within the relationship. Namely, the relationship which they rely on to regulate their emotions is now dysregulating (Lyons-Ruth & Spielman, 2004). Nevertheless, the dyadic model of emotional regulation suggests that the individual's affect-regulatory capacities are based in how mother and infant mutually coordinate their emotions to adapt to one another. Optimally, each partner should be engaged and oriented toward one another even when it is hard to do (Fosha, 2001). Contrary to individually oriented theories of behaviour, which focus on the individual as a primary point of reference, the family systems theory comes to the fore, exchanges of behaviour that take place in interactions between members of the family as a circular conception of causality, rather than lineal (Johnson & Ray, 2016).

Listening to Josh's mother speaking of him was not easy for me. She spoke about him in terms of exploitation, saying, for example, "I give him lots of TLC and I still feel he is taking advantage of it, wanting more and more from me". Taking into account her distress, I concluded that Josh's most significant figure, his mother, found it difficult to accept him. She also critically described the father as not taking any significant part in caring for the children. They both sounded overwhelmed, however, and not available to their other children. Thus, based on the understanding that any change in the therapeutic process with Josh would be hard to implement without an essential change in family relationships, I made a strong recommendation that they should attend a class for parental guidance and support. My impression of the mother's perception of my recommendation was of serious listening, as she respected my professional role as her son's music therapist and intended to implement my advice. Though, she would take into consideration other communal aspects and prices she might have to pay, such as her social visibility, [9] a component of great importance in the Ultra-Orthodox community.

[9] As it was defined by Clifford (1963, p. 799), "as the position an individual occupies within a group as it is perceived by the other members of the group. This position is achieved through the competencies (skills and attributes), or lack of them, that the individual possesses which are relevant to the on-going processes of the group".

Musical "hide and seek"

In parallel to Josh's growing maturity, our relationship became more and more profound. The tendency to lie on the floor as well as to suck the beanbag chair had been significantly reduced. He engaged in more sharing. At our first meeting after the holidays I felt that we were making further progress because his intonation was less infantile and he had a greater ability to share his experiences of spending time with his family.

Based on the classic children's game "Hide and Seek," we developed our musical "Hide and Seek." The rules were similar to the original game, but with one more musical rule that required me to sound an instrument whilst seeking. Once, in the middle of a game, I pretended I was looking for him inside the ball. As part of the game, I jumped onto the ball. Josh understood this, and suddenly shouted: "Ouch!" For the first time, I heard a very confident voice. I was surprised. Instead of adjusting to him, I experienced him as adjusting to me. He had matched his shout entirely to the jumping movement on the ball. That was a significant moment within the process. Josh, at that point, showed that he had acquired a more mature comprehension of the situation, with spontaneity, creativity, and sophistication.

Later on, Josh chose to play the same game over and over again, asking me to look for him inside the ball. Repetition of the game over and over again creates a ritual. The ritual provides confidence, keeps anxieties at bay, strengthens and consolidates ego forces (Neumann, 2011). Musically, repetitive play has its own rhythm and variations. A kind of musical piece in which the musical motif is repeated in different forms (Rap, 1980). Josh's repetitiveness, as shown through his playing, was very typical for the developmental age of two. By stating his requests, he showed his confidence and his need for sensory contact (Beker & Davidi, n.d). Moreover, from time to time, the game became increasingly interesting as the rules were already clear to us, enabling playfulness to take place, as the rules could be adapted.

A beginning of "self": Analysis

During this period, Josh's "self", which had previously been expressed through his lying on the beanbag chair and asking me to witness him playing, began to become apparent through his motor and verbal responses. He was no longer lying on the floor as he was in the initial visits and was pacing the room more often. His verbal skills began to play a significant role in the process as well. His speech began to sound more coherent, with more precise "self" expression, articulated experiences and sometimes even resistance, which was reflected by challenging the setting, by asking how much time we had left, looking outside and describing what he was going to do after our session. Yet, his musical expression, had still not come to fruition. [10]

Although the decision to come to music therapy was not his choice, Josh eventually wanted to attend sessions, to discover for himself the meaning of being here and who he could be in this space. However, rather than trying to help him to find the appropriate reason for being here, I sought to connect to his "self" experience, i.e. simply being with him during this experience of seeking. I believe I gave him the message that he was important to me whether he chose to be here or not, which strengthened our bond.

[10] The phrase "musical expression" relates to an active initiation of music making (i.e. singing, playing, improvising etc.).

At this point, the picture of what was going on in Josh's home was becoming clear. My feeling was that Josh had been referred to music therapy because of a chaotic family environment, in which his parents found it difficult to establish authoritative parenting rather than permissive parenting, not only for Josh but also for the rest of the household. At some point I realised that music therapy for Josh would not be enough. Therefore, I recommended that Josh's parents seek parental counselling in order to provide them with the appropriate tools for coping with family challenges, including the challenges being posed by Josh. As described previously, my experience with him was of one child with multiple levels of developmental levels. I assumed this was also how his parents felt, hence their sense of worry towards him.

This combination of symptoms, such as intensive regulation difficulties along with unsynchronised development, high mental functioning, and low emotional functioning, are often seen in children who have been diagnosed as gifted (Webb & Kleine, 1993). Sometimes, the very diagnosis of being gifted can have a calming effect on parents as well as on the child, who is now being perceived as "smart" and "special" rather than problematic (David, 2012a). Josh, however, was not diagnosed as such. The most probable reason is that the Israeli education system usually conducts such an evaluation of this nature around the age of seven or eight and Josh was only five years old. Secondly, as part of its conservative perception, the Ultra-Orthodox education system is reluctant to take part in the Israeli giftedness diagnosis examination (David, 2012b).

The situation that ended the current section of the treatment was our musical "Hide and Seek" game. While I was looking for him, Josh gave me an obvious indication of his whereabouts by making a sound that matched my movement. This mutual game, which included communicative matching sounds, musical tension and synchronisation, could be seen in light of the notion of "Communicative Musicality". According to Trevarthen and Malloch (2000, p. 5), "humans commonly interact with one another at great speed, synchronising in subtle and unconscious rhythms of exchange". They call this non-verbal communication "Communicative Musicality", which includes vocal and instrumental sounds as well as bodily gestures in mother-infant, and therapist-patient (Fosha, 2001), relationships that express a motivation for communication (Trevarthen & Malloch, 2000). Communicative Musicality between the mother and her baby is expressed through the exchange of spontaneous and improvisational messages composed of a pulse, pitch, volume, and tone (Malloch, 2000). By listening to the baby's vocal productions and being attuned to his or her arousal and attention, a parent can mimic or repeat the vocal production with some variation or even exaggeration (Stern, 2010).

I was surprised by Josh's ability to understand the situation in the Hide and Seek game and respond to it in a sophisticated way. This type of interchangeable role playing is not entirely unusual. Nonetheless, the initiation that Josh took in his playing stood out against the background of my initial experience of him as an emotionally immature child.

Josh lacked an authoritative parental figure to rely on. He needed and sought a parental figure who would have confidence in him. In Kohut's terms, as explained in Oppenheimer (2000), he was lacking a "Self-Object", i.e. an external figure (who should become internalised in the future) who could help him to develop a healthy sense of "self". Such a figure, however, was not evident to him at home at that time.

Sessions 13-19: Recording

At the central point of the therapeutic process, I exposed Josh to the computer and the various possibilities it offered, especially in the field of recording. Whilst doing so, I suggested to him that he experience recording himself. He agreed to try this, although it was apparent that he was not particularly familiar with the idea. He chose to sing two songs. He started with a very famous Hasidic song, which he had probably heard sung by his family at home. The second song he attempted was an educational children's song that he almost certainly had learnt in his kindergarten. About a week later, Josh proactively requested to record himself, but this time he sounded entirely different. It was as if a dam had been breached. He produced a mixture of nonsense voices and gibberish. Throughout his immature shouts his inner powers are audible, revealed in a raw form, but with potential to be developed as expressive of a powerful personality. Josh's response was fascinating. Each time he listened to his voice he would become overwhelmed and would run to the safety of the beanbag chair and nestle in it.

We continued working with these songs and recordings. Josh kept returning to the recordings and asked to record himself saying "nonsense" (as he called it). Once I decided to suggest that he sing "nonsense" first and then "no-nonsense." Josh accepted my offer and sang the famous Hasidic song he has chosen previously. He then asked me to sing the song on my own with a guitar. I started to improvise the song. At first, I sang it in its original version, but then I made a change and improvised in a way that reflected Josh's actions (as he blew soap bubbles). We stayed with the melody and the rhythm for a while and we both made funny faces until Josh asked to stop. The game went on without music. Josh found another container of soap bubbles and we played together. When he saw that I was having little success blowing my bubbles, he suggested: "Let's trade." I asked him why he wanted me to trade my instrument. He replied that he wanted me to succeed, just like him. During this session (session 15), he also found the Cabasa (an African percussion instrument) that had been completely dismantled and, without any prior knowledge and almost without any help from me, simply put it back together. This session invited me to begin to see Josh, in relation to his emotional age, not as a toddler, as I had first seen him, but as an older child.

In my meeting with Josh's parents, I again strongly advised them to seek parental guidance after realizing that they had not followed this suggestion. I telephoned Josh's mother and she told me that they had decided to take an external training course (not where Josh's treatment took place) offered by a renowned expert from a distant city. She also informed me that they had not seen much improvement with Josh at home. However, she then recanted and admitted that there had been some change. Josh was crying less, he was less sensitive and more obedient. She also confirmed that they were giving him the warmth and love that I had explained he needed at our last meeting.

In session 16, Josh found the book "Monkey Puzzle" in my bookcase. It is a children's book by Julia Donaldson and Axel Scheffler describing the story of a monkey who has lost his mother and who tries to find her with the help of a kind butterfly:

> I've lost my Mom!
> "Hush little monkey, don't you cry,
> I'll help you find her", said butterfly.

> "Let's have a think. How big is she?"
> "She's big!" said the monkey, "bigger than me!"
> "Bigger than you? Then I've seen your Mom.
> Come little monkey, come, come, come."
> (Donaldson & Scheffler, 2000, p.3)

Josh found the book very interesting and asked me to read it to him. During the following sessions, Josh returned repeatedly to this book, asking me to read it to him. He called it "the book about the monkey who has lost his mother." One of the most significant moments relating to the book was my suggestion to Josh that he tell the story by himself, from his viewpoint. He replied that he did not know how to do so. His answer led to a dialogue about how a little monkey feels when he has lost his Mommy. I asked him if he had lost his mother once. At first, he replied "no," but very quickly said: "At home, sometimes I lose my Mom." Josh told me about a few occasions when he realised that he could not find his Mom and Dad and was, as a result, very sad. We kept reading the story as well as talking about Josh's feelings for his mother. Through the dialogue, he managed to place his difficulty with his mother "in the open," i.e., he expressed the difficult feeling that he had experienced when he felt that he had lost his mother in his safest place, home. Moreover, what made Josh's feelings of "losing" his mother even more intricate was the understanding that Josh, who felt very attached to his mother and difficult to be apart from her, was also experiencing a sense of rejection from her.

During session 17, Josh sang the famous Israeli children's song about the wind that caused the apple to fall from the tree. I followed that song with another well-known Israeli children's song and let him complete the ending. He cooperated and tried to complete the song even though it was not clear whether he knew it or not. During that session, we sang a few other well-known Israeli children's song, but he lost patience. He seemed to feel that he was being offered too many songs that he did not know. He expressed this with angry vocal sounds. I responded by verbalizing the anger within a song. I improvised the phrase "I am angry and don't want you to sing it anymore," together with the melody of the last Israeli children's song he was offered. After this, Josh suggested that we play our musical "Hide and Seek" game. Here, for the first time, he accompanied the guitar with free vocal improvisation, which eventually converged to a small familiar melody called "The Canopy Nigun" (A Hasidic melody). This is the most familiar melody from the wide Hasidic instrumental repertoire to Ultra-Orthodox children as they are frequently exposed to it at Hasidic weddings (Seri, 2013). While he started with free improvisation and ended up with the "Canopy Nigun", as soon as I recognised the melody and tried to join him, he stopped. I felt that he was still unable to cooperate. After this, however, we played together for the first time. This took place on two separate xylophones. I played the xylophone pleasant sounds of an open major arpeggio and, by improvising on a simple knitted thirds sequence (C-E-D-F-E-G), invited Josh to join me. He accepted the invitation and tried to join in. At some point, he felt dissatisfied with his sounds and asked me to exchange instruments, which we did and this time he played to his satisfaction.

Recording: Analysis

For the first time in the therapeutic process, Josh's music, including the use of his voice, significantly came to fruition. His choice to sing a very famous Hasidic song with which he was familiar, may have

meant that he was seeking security rather than risk. Josh chanted quite monotonously. His way of singing reminded me of how he lay on the beanbag chair. In other words, although he was familiar with the song, when he was within the unfamiliar place of recording (as this was a new media for him) he returned, literally and emotionally, to his starting point, the beanbag chair which was his safe place. From there he conveyed his feelings through singing. However, there was a marked difference in the way he sang one week later, in session 14. In contrast to the first time I heard him sing, with melody and lyrics sung in a restrained, monotonous, "piano" dynamic level, the second time he sang he did so with an emotional and powerful "fortissimo", utilizing vocal production, murmurs and shouting. He sounded much more vivacious, "naughty" and wild, as well as crude and immature.

Josh's singing grew more and more elaborate as the sessions has proceeded, and he sang with gusto. His singing dynamic was characterised by a "mezzo piano" dynamic level, increasing to "mezzo forte". I felt that his way of singing was intended to exhibit, to me and himself, his capacity to keep his voice consistent by singing more conventionally rather than singing "nonsense". I assumed he was also implicitly showing his capacity to adapt to his community's social conventions. This shifting between different musical expressions indicated the enhance of his capacity to choose and control his choices as well. Through these different musical experiences, Josh could refine his repertoire of abilities, as well as his emotional world and social understanding.

Playing the Hasidic song on my guitar at his request became a game between us, capturing the shared sentiment: "let's keep playing with our common music". Thus, we both created a potential space, in which we played together by composing an improvised song based on the original Hasidic tune including words relevant to Josh's activity in the moment, so that the original song became our song.

Kenny's (1989) "Field of Play" theory relates to a play-musical space in which musical experiences take place throughout sounds expressing special feelings, thoughts, approaches, and values. These can only subsist in the circumstances where trust and confidence prevail between the therapist and his or her patient. Kenny's attitude was based on Winnicott's idea of "potential space" that is created between the mother and her infant and that represents how the infant relies on his or her mother while he or she is away from her while investigating his or her surroundings. This is the very point in which separation between the mother and her infant begins to occur, enabling the new "self" of the baby to emerge (Amir, 1999).

We can now appraise a few remarkable differences between the emotional functioning and developmental levels of Josh at the beginning of the process compared with functioning at this point. As opposed to his lying on the beanbag chair at the beginning of the process, Josh was now prepared to stand up. In contrast to his tendency to stay in a specific place at the beginning of the process, he was now using the entire room. Finally, in comparison to his refusal to accept the legitimacy of my presence ("But I hear you!"), he was now making room for my ideas as he had developed a sense of attachment and we had built an intersubjective relationship. I felt that Josh was looking for a compromise between his desired viewpoint and that of the Ultra-Orthodox community. In other words, he had discerned his need to listen to his inner voice and his need to adapt to the demands of the society in which he lived.

Within a free-flowing conversation about his daily experiences at home and in kindergarten, Josh told me that he was concerned with his position in the hierarchy of "righteousness" by telling me that

he placed himself in "the second place". Being a righteous and pious person is a type of status symbol in the Ultra-Orthodox community. As Josh is five years old, this appears to be a highly abstract thought process for him to have achieved. Yet, as a child, he sought to develop his sense of belonging (Morgan & Kuykendall, 2012). Therefore, he was very attentive to perceive and internalise the communal message. According to his juvenile way of thinking, the communal message he received seemed to be that being a righteous person, whatever "righteous" means, is very important. On the basis of this comprehension he could now begin to reflect on his own sense of his personal characteristics. Thus, by telling me that he placed himself in the second place, which means nearly perfect, he showed his understanding of the importance of meeting the social standards of the community in which he lived, as well as his competitive thinking. In the background, I speculate that this is also connected with his complex relationship with his mother: He desperately needed his mother, while she found it very difficult to accept his complexity and expected me to "fix" him for her.

In our joint playing on the xylophones, I experienced Josh's profound emotional need for attachment. Through my improvisation, I was able to give him a sense of invitation, which he accepted. While playing together, I carefully listened to his dynamics (piano, pianissimo) as well as to his gentle playing and experienced him as a toddler who was asking me (the adult) quietly to protect him by gently following my playing as well as intertwining with it. I heard his xylophone sounds blending with mine, rather than being engulfed.

The second encounter with Josh's parents

As on previous occasions, Josh's mother once again arrived at our meeting without her husband. However, this time she was much more relaxed, both in her body language and intonation. She came with many questions and was prepared to listen. She told me that the kindergarten teacher had told her that Josh's previous daily crying duration of two hours had been reduced to 10 minutes. I lent an attentive ear to her and found her more confident and more focused. She said that in spite of her difficulties, she had decided to accept my guidance and apply my advice, although she had received different advice from the kindergarten teacher who recommended a stricter approach.

From her description it became obvious that at home Josh was beginning to express his sense of being a separate, independent self. For instance, she told me that when she had suggested that he should play quietly in his room she noticed him lying on the floor, sucking his finger. When she asked him why he was not playing, he replied: "Mom, that's how I babysit myself." She said she had made another definitive decision; to honestly see him, to be with him as needed, to understand his viewpoint, and most significantly of all, to happily accept him. She told me that the parents' training they had attended had helped them immensely, especially in dealing with their other children. Josh's father, however, was still not involved in the therapeutic process. His mother continued to decry his bonding with Josh but did not object to his presence. In practical terms, it had not occurred yet.

Sessions 20-25: Josh creates and verbally expresses assembled emotions

Earlier I described Josh's unique bonding with the beanbag chair in the beginning of the therapeutic process. He regarded it as his safe place. In subsequent meetings, Josh discovered the beanbag chair also had another dimension. He found that he could get into the beanbag chair. His entry into the

beanbag chair happened gradually. I accompanied the whole event with a guitar improvisation. Josh lay down on the beanbag chair; slowly he opened it and discovered that it contained an inner part filled with many tiny polystyrene balls. He was fascinated and slowly drawn, both physically and emotionally, into the ambience until he went inside the beanbag chair. He then shuffled around the room whilst he was inside the beanbag. I experienced his movements as cumbersome, however, I sensed that he was extremely happy and seemed not to feel the awkwardness. Josh's sense of happiness led him to a burst of creativity and musicality. He wanted to compose a song, and also to play and sing other songs he knew. I felt he was so inspired, that his consciousness was not focused on reality. His thoughts were elsewhere. At the end of the session, I sang him a song aimed at bringing him back to reality from the consciousness of merging with the beanbag chair.

At the next meeting Josh kept making a beeline for the beanbag chair. While doing so, I initiated the introduction of the book "The Little Boy Likes, The Little Boy Dislikes" by Nurit Cohen (2002). On alternate pages of this book there are rhyming sentences about things that children like and do not like. I introduced the book with music by improvising a melody accompanied by the guitar. Josh did not oppose this, did not ask me to stop, and showed some interest. He initially distanced himself from the child in the book in many ways, however. For example, Josh described himself in opposite terms ("Everything the little boy doesn't like, I do like"), or he asked me to "read it from the book" when he thought I expected him to contribute his own lyrics. However, during the session, he slowly came closer to me. When we sang about what the little boy likes, Josh still wanted me to sing about the little boy but not him. However, at the same time, he made up his own lyrics that showed me he understood precisely at whom the song was aimed. For example, he paraphrased the line, "The little boy likes to go to his friends, but his mother doesn't allow it ...". Josh was asking me to continue to sing about what the little boy in the book does not like, but he wanted me to improvise the lyrics, which were about him, without his input. On one hand, I felt a desire to fulfil his request, but on the other hand, I did not know what his preferences were. I felt that the subtext of his request was to involve me. I, therefore, extracted and utilised information about things he did not like from personal hints he had given me.

He was apparently feeling his discontent until he finally said the sentence: "I do not like my mother constantly annoying me and telling me not to do something ...". For the first time in the therapeutic process, Josh verbally, and in an age-appropriate manner, expressed his anger concerning his mother. At the same time, he also established his emotional capacity to feel separate from her. Moreover, he expressed a complex emotional message and told me how she does not let him choose a bag he loves. He said, "But today she allowed me to choose and that's what I like. Now please sing about the things Josh likes."

Josh creates and verbally expresses assembled emotions: Analysis

The current section is the most significant within the process. Our bonding and attachment had enabled me to challenge Josh with children's songs he did not know and that did not even belong to his cultural repertoire. My decision to expose him to these songs was derived from their compatibility and relationship to his emotional stage. The mixture of both unfamiliar and compatible songs in an appropriately balanced manner also enabled him to contain himself, as well as being angry when he was tired of them. Josh told me that he was enjoying our sessions, which was corroborated by his mother. At home, Josh also became aware, with focused and sensitive intuition, of who was pleased

with him and, alternatively, who was restraining him. Josh continued moving throughout the mature-immature/ unrestricted-detained dialectical axis, having his various dimensions forming a splendid complexity.

Josh was extremely excited by the opportunity to get into the beanbag chair. It seemed to me as if in one act of getting into it he encapsulated two intentions. While he was fusing with his safe place, the beanbag chair, he was separating from me as well. Separating from me also entailed authentically connecting to himself, that is, leaving me at the beanbag chair's external envelope (i.e. the room space) and asking me to take part in his playing as an active observer.

His fusing with the beanbag chair could be interpreted in relation to his will to deepen his relationship with it, separate from his external world and community. The beanbag chair was highly flexible and containing. It would always gain the shape of the one who would repose on it. Being in such a world may have led to Josh feeling omnipotence. Consequently, I felt the desire to give words and melodies to this unique experience in order to reflect Josh's emotional world. I played a simple rhythm on the guitar and added a recitative and easy, accompanied melody.

Feeling he was omnipotent, for the first time Josh expressed his willingness to sing a song, and even composed one by himself, which he had been unable to do before. A review of his short song revealed a high level of organisation. Its squared structure contained four bars each of 4\4 meter: "I'm in the beanbag, I'm in the beanbag, bag, bag, bag." Josh used a happy staccato rhythm. The melody began with a downward trend and rose again towards its end, with repetition that sounded like a bouncing ball within the beanbag: "bag, bag, bag." Also, the phrase: "I'm in the beanbag" comprised two stable intervals – a second and a third - which appeared in the first section as well as in the second. Towards the Coda, the melody returned as a variation of the melody at the beginning. His singing style, as well as his voice, became age-appropriate. His voice now sounded stable, with the capability to keep the melody from start to finish. The musical structuring as well as the very ability to improvise such a song, attested to a more advanced and organised "self," which was capable of containing internal discourse, consistency, and a clear message.

Sessions 26-30: Farewell

The sessions that took place in the expected farewell process included a joint listening to Hasidic music chosen by Josh and joint "nonsense" singing. The feeling was of being together. Josh appeared to sense that this was our ending phase. He did not bring up new things, just letting us be together. It should be noted that Josh's mother had altered her approach towards him and even participated in two dyadic sessions near the end of the therapeutic process. Eventually, I realised that although he underwent a significant process, Josh did not really want to relinquish his vivid character and did not want to try to be what/who he was not. Additionally, the Ultra-Orthodox society in which he lived probably would not be changed either. However, what was important to me, and indeed it did happen, was to create a space for Josh to be able to say this to himself as well as to his family. Once he even tried to telephone his father, who was not as involved in the process, and tell him about what we were doing together. Unfortunately, he was unavailable.

More and more, I experienced Josh as a mature boy, explaining himself eloquently. The complexity of being "naughty" as well as religious, in an environment that is less tolerant to his playful

side, dwelled in his consciousness. While there were aspects that Josh was working on, there was also a need for Josh's family members to undergo their own process more broadly. I believe that the process that Josh and I began together could eventually expand.

During our last session, he wrote on the board "From Josh who..." and then asked me to write "was inside the beanbag chair." He then said: "I want you to tell whoever comes after me, that there was a kid here called Josh and he played with the beanbag chair". I also asked him what he would wish this child to think about him after they read it, and he answered: "I really don't care, let them think what they want."

Farewell: Analysis

Josh allowed me, and allowed himself, to feel what was truly going on within his relationship with his mother. He discovered mixed feelings of loss, need, and dependency, which had become feelings of anger. At the same time, I recognised a maturity in him, e.g. that he knew how to be angry without losing control, as well as understanding the complexity of the relationship: His mother's actions would sometimes satisfy him, and sometimes would not. From our mutual experience, we prepared for our farewell, which Josh seemed to accept. At our final meeting he did not create anything new, nor did he open new topics, but only asked that we listen together to the music he loved. Once again, he revealed his musical preferences for more romantic and sensitive songs. He remembered his favourite melodies and asked to hear them again.

CONCLUSION

Compared to his chaotic reality at the beginning, Josh's "self" had been moulded into a more coherent and consistent figure. He was now much more aware of what was happening to him. The question that remains in my mind is whether Josh's parents understood that the potentially difficult road ahead towards Josh's continued well-being may be partially dependent on their ability to change. One significant insight I have absorbed from this process is the comprehension of the complexity of achieving the therapeutic goals while knowing that the patient's well-being and welfare is a factor of his private, family and social-cultural environment. It seems that all these dimensions came together to show me that in the Ultra-Orthodox community in which Josh lives it is not enough for him to mature by accepting and being comfortable with himself, and even being able to project this out to society. Both his community and family need to embrace his uniqueness. Eventually, they are the ones who will give Josh the impetus to grow. His quality of life is first and foremost derived from his affiliation to the general society in which he lives.

REFERENCES

Amir, D. (1999). *Meeting the sounds: Music therapy: Practice, theory and research* [in Hebrew]. Bar-Ilan University.

Beker, A., & Davidi, L. (n.d), Preschoolers' playing [in Hebrew]. https://www.itu.cet.ac.il/%D7%94%D7%9E%D7%A9%D7%97%D7%A7-%D7%91%D7%92%D7%99%D7%9C-%D7%94%D7%A8%D7%9A/

Belsky, J. (1984). The determinants of parenting: a process model. *Child development, 55*, 83-96.

Bodner, E., Iancu, I., Gilboa, A., Sarel, A., Mazor, A., & Amir, D. (2007). Finding words for emotions: The reactions of patients with major depressive disorder towards various musical excerpts. *The Arts in Psychotherapy, 34*, 142–150.

Bruchin, E. (2014). *The willingness to applying for professional-mental help in Ultra-Orthodox society* [in Hebrew]. [Master's thesis, University of Haifa]. http://www.imc.org.il/wp-content/uploads/2016/03/%D7%91%D7%A8%D7%95%D7%9B%D7%99%D7%9F-2014-%D7%98%D7%99%D7%A4%D7%95%D7%9C-%D7%A0%D7%A4%D7%A9%D7%99-%D7%97%D7%A8%D7%93%D7%99%D7%9D-1.pdf

Clifford, E. (1963). Social visibility. *Child Development*, *34*(3), 799-808.
Cohen, N. (2002). *The little boy likes, the little boy dislikes*. Korim.
David, H. (2012a). Diagnosing gifted child. http://www.hebpsy.net/articles.asp?id=2779
David, H. (2012b). The Jerusalemite Abraham Isaac: My encounter with an Ultra-Orthodox gifted child. https://www.hebpsy.net/articles.asp?id=2838
de la Torre-Luque, A., Caparros-Gonzalez, R. A., Bastard, T., Vico, F. J, & Buela-Casal, G. (2017). Acute stress recovery through listening to Melomics relaxing music: A randomized controlled trial. *Nordic Journal of Music Therapy, 26*(2), 124-141.
Degangi, G.A., Breinbauer, C., Doussard, Roosevelt J., Porges, S., & Greenspan, S. (2000). Prediction of childhood problems at three years in children experiencing disorders of regulation during infancy. *Infant Mental Health Journal, 21*(3), 156-175.
Donaldson, J., & Scheffler, A. (2000). *Monkey puzzle*. Macmillan Children's Books.
Eckhardt, K. J., & Dinsmore, J. A. (2012). Mindful music listening as a potential treatment for depression. *Journal of Creativity in Mental Health, 7*, 176-186.
Fink-Kronenberg, I. (2007). Emotion regulation in infancy [in Hebrew]. http://www.hebpsy.net/articles.asp?id=1223
Fosha, D. (2001). The dyadic regulation of affect. *Journal of Clinical Psychology, 57*(2).
Friedman, M. (1991). *The Haredi society: The Ultra-Religious community in Jerusalem* [in Hebrew]. Mahon Yerushalayim Leheker Israel.
Friedman, M., & Shelhav, Y. (1985). *Spreading but staying secluded: The Haredi community in Jerusalem* [in Hebrew]. The Jerusalem Institute for Israel Studies.
Ghazban. N. (2013). Emotion regulation in infants using maternal singing and speech. [Doctoral dissertation, Ryerson University]. http://digital.library.ryerson.ca/islandora/object/RULA%3A3131/datastream/OBJ/Emotion%20regulation%20in%20infants%20using%20maternal%20singing%20and%20speech
Gross, J. (2014). Emotion regulation: Conceptual and empirical foundations. In J. Gross (Ed.), *Handbook of emotion regulation* (pp. 3–20). The Guilford Press.
Hess, E., & Pitariu, H. (2011). Psychotherapy of ultra-orthodox Jews in Israel – a qualitative assessment of conflicts and reconciliations. *Europe's Journal of Psychology, 7*(3), 502-533.
Hoffman, S., & Ben-Shalom, H. (2001). Reflections on working in an Ultra-Orthodox mental health clinic. *International Journal of Psychotherapy, 15*(3), 43-51.
Huppert, J. D., Seiv, J., & Kushner, E. S. (2007). When religion and obsessive–compulsive disorder collide: Treating scrupulosity in ultraorthodox Jews. *Journal of Clinical Psychology, 63*(10), 925–941.
Jemstedt, A. (2019). Being, creativity and potential space, 1969-1971. In A. Treacher Kabesh (Ed.), *Twelve essays on Winnicott.* (pp. 165-181). Oxford University Press.
Johnson, B. E., & Ray, W. (2016). Family systems theory. In S. Smith (Ed.), *The Wiley Blackwell encyclopedia of family studies* (pp. 782-787). Wiley-Blackwell Publishing.
Kenny, C. B. (1989). *The field of play: A guide for the theory and practice of music therapy.* Ridgeview Publishing Company.
Lyons-Ruth, K., & Spielman, E. (2004). Disorganized infant attachment strategies and helpless-fearful profiles of parenting: Integrating attachment research with clinical intervention. *Infant Mental Health Journal, 25*, 318–335.
Malloch, S. N. (2000). Mothers and infants and communicative musicality. *Musicae Scientiae, 3,* 29-57.
Marik, M., & Stegemann, T. (2016). Introducing a new model of emotion regulation with implications for everyday use of music and music therapy. *Musicae Scientiae, 20*(1), 53-67.
Morgan, E., & Kuykendall, C. (2012). *What every child needs*. Bondfire Books.
Music, G. (2014). The buzz trap: Speeded-up lives, distractedness, impulsiveness and decreasing empathy. *Psychodynamic Practice*, *20*(3), 228-249.
Neumann, E. (2011). *The child: Structure and dynamics of the nascent personality* [in Hebrew]. Hasinut.
NICHD. (2004). Affect dysregulation in the mother-child relationship in the toddler years: Antecedents and consequences. *Development and Psychopathology*, *16*, 43-68.
Oppenheimer, A. (2000). *Heinz Kohut* [in Hebrew]. Tolaat Sefarim.
Rap, U. (1980). *The world of playing* [in Hebrew]. Ministry of Defense.
Schnall, E. (2006). Multicultural counseling and the orthodox Jew. *Journal of Counseling & Development, 84*, 276-282.
Seri, N. (2013). *What would you sing to ultra-orthodox children?* [in Hebrew] [Unpublished thesis, Bar-Ilan University].
Seri, N., & Gilboa, A. (2018). When music therapists adopt an ethnographic approach: Discovering the music of ultra-religious boys in Israel. *Approaches: An Interdisciplinary Journal of Music Therapy*, *10*(2), 189-203. http://approaches.gr/seri-a20170308/
Sheleg, Y. (2000). *The new religious Jews* [in Hebrew]. Keter Publishing House.
Skanland, M. S. (2013). Everyday music listening and affect regulation: The role of MP3 players. *International Journal of Qualitative Studies on Health and Well-being, 8.* https://www.tandfonline.com/doi/full/10.3402/qhw.v8i0.20595
Stern, D. N. (2005). *The interpersonal world of the infant* [in Hebrew]. Modan.
Stern, D.N. (2010). The issue of vitality. *Nordic Journal of Music Therapy, 19(2),* 88-102.
The Ultra-Orthodox Forum for Arts Therapists (n.d). https://www.forumtaplot.co.il/
Thoma, M. V., La Marca, R., Brönnimann, R., Finkel, L., Ehlert, U., Nater, U. M., & Newton, R. (2013). The effect of music on the human stress response. *PLoS One, 8,* e70158.
Trevarthen, C., & Hubley, P. (1978). Secondary Intersubjectivity: Confidence, confiding and acts of meaning in the first year. In A. Lock (Ed.), *Action, gesture, and symbol* (pp. 183-229). Academic Press.
Trevarthen, C., & Malloch, S.N. (2000). The dance of wellbeing: Defining the musical therapeutic effect. *Nordic Journal of Music Therapy. 9,* 3-17.
Webb, J.T., & Kleine, P.A. (1993). Assessing gifted and talented children. In J. Culbertson and D. Willis (Eds.), *Testing young children* (pp. 383-407). PRO-ED.
Winnicott, D. W. (1958). Primitive emotional development. In D. W. Winnicott, *Collected papers: Through paediatrics to psychoanalysis* (pp. 145-156). Tavistock Publication.

Winnicott, D. W. (1995). *Play and reality* [in Hebrew]. Am Oved.
Yafeh, O. (2004). *Becoming an Ultra-Orthodox girl: Socialization practices, pedagogical discourse and self-construction* [in Hebrew]. [Unpublished doctoral dissertation, Hebrew University of Jerusalem].
Yehuda, N. (2005). *Characteristics of the cross-cultural encounter in music: Between therapist and client in music therapy, and between the musician and the music in the process of performing* [in Hebrew]. [Unpublished doctoral dissertation, Bar-Ilan University].
Yona, Y., & Goodman, Y. (2004). Religiosity and secularism in Israel: Other alternative perspectives. In Y. Yona & Y. Goodman (Eds.), *Maelstrom of identities: A critical look at religion and secularity in Israel* (pp. 9-46). The Van Leer Jerusalem Institute.

Ελληνική περίληψη | Greek abstract

Μία κλινική μελέτη περίπτωσης: Μουσικοθεραπεία με ένα Υπερ-Ορθόδοξο Εβραίο αγόρι με δυσκολίες συμπεριφοράς και αναπτυξιακές ελλείψεις

Nir Seri

ΠΕΡΙΛΗΨΗ

Αυτή η μελέτη αφορά τον Josh, ένα Ισραηλινό πεντάχρονο παιδί, σε μία Υπερ-Ορθόδοξη Εβραϊκή κοινότητα. Ο Josh (ψευδώνυμο), παραπέμφθηκε για μουσικοθεραπεία λόγω της μη-συμβατής για την ηλικία του ανάπτυξη και τις δυσκολίες του ως προς την συναισθηματική του αυτορρύθμιση. Οι τρόποι έκφρασης των συναισθημάτων και των συμπεριφορών του Josh θεωρήθηκαν αντικρουόμενες με τις Υπέρ-Ορθόδοξες κοινωνικοπολιτισμικές συμβάσεις. Η οικογένεια και η κοινότητα εντός της οποίας ζούσε ο Josh δίσταζαν να συμπεριλάβουν και να αποδεχτούν τις δυσκολίες του. Ως ένας μη Υπερ-Ορθόδοξος μουσικοθεραπευτής, η διαπολιτισμική θεραπευτική διαδικασία ανέδειξε ουσιαστικά ερωτήματα σχετικά με τον ρόλο μου στην φροντίδα του Josh. Ένα ερώτημα ήταν το εάν όφειλα να βοηθήσω τον Josh να αποκαλύψει την αυθεντική ζωηρή προσωπικότητά του, σε αντίθεση με τις συμβάσεις της κοινότητάς του, ή αντιθέτως να τον βοηθήσω να ανταποκριθεί στις απαιτήσεις της συντηρητικής και αυστηρής κοινότητάς του. Κατά τη διάρκεια της θεραπευτικής διαδικασίας, η μητέρα του Josh εξέφρασε δυσκολία στο να αποδεχτεί τον χαρακτήρα του, κάτι που θεώρησα ως ένδειξη απόρριψης. Αυτή η εμπειρία φάνηκε να προκαλεί φόβο στον Josh ότι μπορεί να εγκαταλειφθεί από τη μητέρα του και να αποζητά έναν δεσμό προσκόλλησης με κάποιον που τον κατανοεί και τον αποδέχεται. Κατά τη διάρκεια των συνεδριών παίζαμε, αυτοσχεδιάζαμε, τραγουδούσαμε και δημιουργήσαμε μια αίσθηση σύμπνοιας. Ως αποτέλεσμα, ο Josh αισθάνθηκε άνετα να εκφράσει την ζωηρή προσωπικότητά του. Έτσι, το παιδί που ξεκίνησε με μία ανώριμη δυνατότητα αυτοέκφρασης, ανέπτυξε αυτορρυθμιζόμενη συνοχή έκφρασης μέσω της φωνής, των ηχογραφήσεων, των αυτοσχεδιασμών και της επικοινωνιακής μουσικότητας. Η θεραπευτική σχέση που δεν επιχείρησε να τον «διορθώσει» αλλά να τον συμπεριλάβει και να τον αποδεχτεί, οδήγησε τον Josh να υιοθετήσει πιο αποτελεσματικές στρατηγικές συμπεριφοράς, επικοινωνίας και συναισθημάτων, που με τη σειρά τους βοήθησαν στην κατάκτηση συναισθηματικής αυτορρύθμισης. Συμπερασματικά, ο Josh κατόρθωσε ως παιδί να διατηρήσει την πολυπλοκότητα της έντονης προσωπικότητάς του αλλά και να αποδεχτεί τις συντηρητικές κοινωνικές συμβάσεις της Υπερ-Ορθόδοξης κοινότητας.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

δεσμός προσκόλλησης, συναισθηματική ρύθμιση, απορρύθμιση, Υπερ-Ορθόδοξος, αναπτυξιακές ελλείψεις, διαπολιτισμικότητα, εαυτός

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APPROACHES

ARTICLE

How music-for-health practitioners' decision-making processes inform their practice in paediatric hospitals

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ABSTRACT

This qualitative research study investigated how music-for-health practitioners make sense of decision-making in the context of paediatric hospital wards in the UK. Whilst existing studies have explored the skills practitioners develop and how these relate to outcomes and benefits of music for health, this article describes specifically the process of decision-making and how practitioners drew on previously attained skills. Four music-for-health practitioners, all of whom work in paediatric hospital wards in the UK, were interviewed regarding their experiences of making decisions. The interviews were semi-structured. Data were analysed using thematic analysis and the following themes emerged: (i) Building the foundations; (ii) Taking note and taking in; (iii) Performance conditions; and (iv) Forms of communication. The research is addressed to music-for-health practitioners at the beginning of their careers, offering ways to understand the process of decision making. It might also support more experienced practitioners to understand and reflect on their professional decision-making processes and to have an evidence base to use when training new practitioners. With its focus on the paediatric hospital, this article also has possible multi-disciplinary relevance in helping doctors, nurses and other staff better understand music-for-health practice.

KEYWORDS

decision making, paediatric hospital, music for health

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INTRODUCTION

Decision-making is crucial to musical participation. Qualities required of performing musicians include expertise, analysis and intuition (Bangert et al., 2014) on the one hand and judgement and self-critique (Chaffin & Imreh, 2001) on the other. Practice forms a substantial part of musicians' preparation, as they decide what to play and how to play it, such as what tempo to take and which markings to observe, if reading from a score (Howat, 1995). Musicians' decisions can also be based on how recordings sound, to replicate a style or create a new interpretation. Performers might sometimes decide to counter something they did previously, by constantly analysing their practice and the choices they make (Chaffin & Imreh, 2001). These decisions are described as intuitive and cognitive processes (Bangert at el., 2013) with some musicians favouring unconscious decisions and others taking a more rigorous approach and consciously analysing their choices, as they prepare for concerts and other performances. Improvisation also requires multiple musical decisions. These are often spontaneous, such as responding to other musicians, maintaining the musical feel, or being led by one's initiative to create something new (Wilson & MacDonald, 2015).

Decision-making is no less important for musicians working in healthcare settings. Here, they face the challenge of making not only musical decisions, but also ones that relate to the wellbeing of participants, whether consciously or otherwise. Throughout history, music has been used to improve health and wellbeing; this continues in many ways today (MacDonald et al., 2012). It is used in multiple healthcare settings, including dementia care, mental health support and within community music projects (Sunderland et al., 2018). Music's value for health lies in that it is emotional, ubiquitous, engaging, distracting, physical, ambiguous, social and communicative, and affects behaviours and identities (MacDonald et al., 2012, pp. 5-6). 'Music for health' in the UK uses these characteristics and affordances in promoting wellbeing, through attending to people's social, emotional and physical needs, often when they are dealing with ill health. Whilst the term 'music for health' is not universal, and usages differ between countries, the scope of music for health and wellbeing is vast, and can be seen in a variety of settings, including hospitals.

Music in hospitals in the UK comes in different forms, with the three following instances highlighted by Trondalen and Bonde (2011). First, music medicine aims to improve a patient's wellbeing through the use of pre-recorded music, often during medical interventions and rehabilitation. Second, music therapy is based on the relationships between the music, the patient and the therapist. It concentrates on inter-personal and inter-musical relationships, normally using improvised music that is most often created and altered to fit the purpose by the therapist. Therapeutic music is the third form, and this includes work carried out by music-for-health practitioners, whose "function within the hospital can be to ease suffering, alter mood or support progression to recovery" (Hawley, 2018, p. 10). It is difficult to provide a definition of music for health in the UK, as "there are indeed a range of musicians working within 'health'" (Hawley, 2018, p. 9), with differing professional backgrounds and qualifications. However, music-for-health work is undertaken by "musicians who receive a very specific training in approaches to practice in hospital and healthcare settings" (Hawley, 2018, p. 9). In paediatric hospitals in the UK, music for health can be organised by services such as the Play Department (Great Ormond Street Hospital, 2018) and the Therapeutic and Specialised Play Service

(Manchester University NHS Foundation Trust, 2020) or by hospitals' arts teams such as Artfelt Sheffield (Artfelt, 2020) and Breathe AHR (Breathe AHR, 2020).

Music-for-health practitioners can draw on their experience making musical decisions and transfer this to their practice in health settings. However, such practitioners have to understand how such processes operate in contrasting environments, such as hospitals. The aim of this paper is therefore to explore the decisions that music-for-health practitioners make when working on the wards of paediatric hospitals. The results will be useful for music-for-health practitioners at the beginning of their careers to help them understand the concept of decision-making in this setting and to apply the findings to their own work. It also aims to support more experienced practitioners to understand and reflect on their personal decision-making processes, and to have an evidence base to use when training new practitioners. With its focus on the paediatric hospital, this article also has possible multi-disciplinary relevance in helping doctors, nurses and other staff to better understand music-for-health practice.

LITERATURE REVIEW

Research into the role of the arts in improving health and wellbeing is substantial, with benefits relating, broadly speaking, either to prevention and health promotion, or the management and treatment of ill health (Fancourt & Finn, 2019). Looking specifically at children in hospitals, live music interventions have helped "to reduce anxiety and pain and improve mood and compliance with medical procedures" (Fancourt & Finn, 2019, p. 34). In these ways, music in hospitals supports the needs of patients and their families, running alongside the work and goals of clinical staff, with music therapists and music-for-health practitioners working not only in bays, treatment rooms and by the bedside in the wards (Edwards & Kennelly, 2016), but also in clinics, waiting rooms and public spaces (Preti & Welch, 2012a). Aiding clinical work in the hospital was noted by Wood et al. (2016) as a way to ensure the growth of music therapy services in the NHS. Complementing the primary focus of care within the medical model is not the sole aim in this field however, with benefits emerging for the general wellbeing of patients, hospital staff and families alike (Youth Music, 2017). In one instance (Music in Hospitals and Care, 2018), benefits included reducing the stress and anxiety of patients with dementia, whilst increasing the welfare of the staff and family around them. Hallberg and Silvermann (2015) recorded the views of staff about their experiences of music in hospitals and noted only positive effects, such as aiding non-medical procedures, relaxing patients and creating a calming atmosphere, without being overpowering. In areas of patient wellbeing, music in hospitals has been noted to enhance quality of life in paediatric palliative care (Sheridan & McFerran, 2004) and as a way of aiding the emotional and psychological state of the patients (Avers et al., 2007). Turning specifically to paediatrics, in another study (Reid, 2016), adolescents with life-limiting cancer experienced music making as an opportunity for normalcy, to experience laughter and fun, especially in interacting with their peers. Musical participation afforded them "the opportunity to keep living whilst receiving palliative care" (Reid, 2016, p. 74).

Youth Music (2017) found music in healthcare to have social, personal, musical and workforce outcomes, whilst supporting the wider needs of the hospital. Using the lens of community music, Harrop-Allin et al. (2017) reflected on the experiences of patients, staff and families during a project

to bring fourth-year music students into a hospital. They found that "live music performances may be able to humanise hospital spaces, enabling different modes of musical engagements that confer agency and control to patients, their carers, and nurses" (p. 56). Patients have been observed to gain confidence through playing music, finding a way to communicate through sounds and instruments (Wetherick, 2014) and become relaxed in the hospital environment, with nurses commenting on reduced anxiety and calmer patients (Preti & Welch, 2012a). Many hospital staff referred to the benefits of multi-disciplinary working as "the opportunity to share learning with those of either the same or different disciplines, developing different ways of thinking about how music and healthcare interact and work together" (Youth Music, 2017, p. 10). Music making in this instance created community within an emotionally challenging environment. These multiple outcomes are interesting in relation to the experiences of practitioners and how working in hospitals affects their practice and more specifically their decision-making.

Hawley (2018), in a case study of her own practice in a paediatric hospital setting, explored the process and factors of long-term residencies. She noted that, through promoting interaction and opportunities for expression, such programmes are beneficial for patients and musicians, who experienced reduced anxiety and a deepening of creative and reflective practice, respectively. Hawley (2018) reported that patients find their own voice through music, with musicians listening to them, responding to their actions and ultimately creating compositions. Furthermore, musicians challenge themselves with memorised and improvised repertoire, the creation of new music and the subtlety of making changes to suit the individual. Together, through regular interactions, all these elements of practice are developed over time.

For many musicians, music for health has become a valid career path. Transferable skills are essential when developing from musician to music-for-health practitioner (Hawley, 2014). Petersson and Nyström (2011) investigated how musicians train to be music therapists, discovering that they learn through conversion, openness, reflection and practice. Their study, even though focusing on music therapy, shows how trainees build from one skill to the next during the training process, and this might be relevant for understanding how music-for-health practitioners reflect on their training. Although Petersson and Nyström's study is particularly useful for understanding how musicians draw on their previous musical skills and their use of reflection, it does not investigate how the musicians react to a patient's needs, including what they read from the individual and the setting or how this affects the decisions they make.

Preti and Welch (2013) used thematic analysis to investigate the reasons musicians go into music-for-health work and how they subsequently view their professional identity and develop skills within this field. Participants in their study commented on the ability to "decode" a situation (Preti & Welch, 2013, p. 369) and react spontaneously during an interaction, drawing on skills such as non-verbal communication and flexibility within a planned session, and attributes such as confidence. All of these abilities and attributes helped practitioners guide the interaction, each time being more confident as they learn from the past. However, Preti and Welch (2013) did not research this process of decoding, be it of a situation, a patient's personal demeanour or the practitioner's feelings as part of the decision-making process.

A critical level of decision-making was apparent in Loth's study (2017) of work with a mother and triplets for music therapy sessions. Loth commented on the constant shift of emotions in the room,

the challenges of deciding which child to focus on and the complexity of the mother-child relationships. This study is a useful first-person reflection on the feelings and experiences of the music therapist and the necessity of using these experiences to make future decisions. It gives a small insight into the challenges of making decisions in a very fluid environment. Whereas Loth focused on regular therapeutic sessions with the same group, the current article researches these decisions in the larger environment of a paediatric hospital ward.

Decisions come from the ability to choose, and perhaps the most important choice in music-for-health work is the patient's decision whether to engage with music at all. Sheridan and McFerran (2004) researched how music therapists read body language and other non-verbal cues to determine if a child in palliative care wants to engage with music. The researchers found that, when children did engage, the process was child-centred; that is, the therapist listened and responded, offering choices based on the child's behaviour. This then developed into interpreting the child's musical preferences with the therapist tailoring the session accordingly and enhancing the child's quality of life as they developed a sense of responsibility and autonomy in creating their personal session. This article looked at decision making from the point of view of the reactions and choices of the child in palliative care, particularly regarding quality of life. Whilst Sheridan and McFerran (2004) explored this in relation to music therapists, the current article investigates the patient-led nature of decisions that music-for-health practitioners make in their practice, whilst also considering the wider hospital, staff members and family. Finally, Kern (2011) has investigated the processes of decision-making for evidence-based practice (EBP) in music therapy. She identified individual client factors, clinical expertise and the best available research evidence as the main elements of EBP. Whilst her focus (early childhood music therapy) relates to this study, her purpose was to examine existing models of evidence-based medicine and apply these theoretically to music therapy.

Therefore, the present article differs from the above-mentioned studies in exploring the process of the decisions made prior to, during and after musical interactions with patients and how practitioners decide which skills to draw on and tools to use. It does so within the specific context of paediatric hospital wards in the UK. This research explored how practitioners make sense of their decision-making process, focusing on the knowledge required to make these in-the-moment decisions. The research question for this study was: How do music-for-health practitioners make sense of their decision-making whilst interacting with patients in paediatric hospital wards?

PROCEDURE

As a qualitative study, this research aimed to explore decision making for music-for-health practitioners. A qualitative approach allows us to "explore the complex set of factors surrounding the central phenomenon and present the varied perspectives or meaning that participants hold" (Creswell, 2011, p. 129). The descriptive and in-depth nature of the data made for a rich account of the phenomenon, as understood by the participants and researcher (Merriam, 2002).

Four music-for-health practitioners were recruited purposively because they had experience working on paediatric hospital wards. Participants chose to remain anonymous in the research outputs, therefore they were given pseudonyms (see Table 1).

Participant	Pseudonym	Total years of experience
1	Sophie	13
2	Reuben	10
3	Fiona	7
4	Claire	1

Table 1: Research participants' pseudonyms and total years of experience

The participants' work ranged from playing music in the general ward space and play rooms, to four-bed bays and isolation rooms. Wards differed depending on the needs of the patients. All participants had varied experience of working on specific wards, such as the intensive care unit, long-term ventilation ward and burns unit, as well as less specialised wards.

Research participants were interviewed individually by phone. A semi-structured interview allowed them to explore their understanding and experience of decision-making with the interviewer (see Appendix for interview questions). Fourteen prepared questions gave opportunities for the researcher to prompt and participants to extend responses, as appropriate. Interviews lasted approximately 30-40 minutes and yielded a rich, yet manageable, data set.

Interviews were audio-recorded and transcribed verbatim. Transcripts were analysed using thematic analysis (Braun & Clark, 2006), a flexible method that relies on an interpretivist approach, identifying meaningful elements of the data. Transcripts were studied iteratively and coded before proposing themes and sub-themes. The data set was analysed and coded as a whole and inductively, that is without any prior theoretical assumptions. To reduce bias, the researchers took a reflective approach and discussed the analytical process collaboratively. The study was granted ethical approval by the Royal Northern College of Music Research Ethics Committee (27/06/2018) and all participants gave their informed consent.

RESULTS AND DISCUSSION

Through analysing the data, the following themes and sub-themes emerged (see Table 2). These will be discussed below, using representative quotes from participants.

Themes	Sub-themes
Building the foundations	• Valuing musical skills and knowledge • Experience working in hospitals
Taking note and taking in	• Reading the moment • Reflection
Performance conditions	• Clinical setting • Spontaneity and intent
Forms of communication	• Musical presentation and choices • Interpersonal interaction

Table 2: Themes and sub-themes

Building the foundations

All the music-for-health practitioners spoke about having to be prepared to make a variety of decisions, and for each participant this preparation took several forms. The preparation undertaken, before any in-the-moment decisions need to be made, acts as a foundation to support the choices the practitioner makes throughout a session. Preparation also means making decisions in advance, whether in relation to the music or decisions based on previous experience.

Valuing musical skills and knowledge

Participants transferred performance skills, such as being proficient on their instrument, being aware of audiences and the ability to play with others, into the ward environment. Fiona said, "I firmly believe that in order to do this job effectively you have to know your instrument back to front and not have to think about it." In addition, Reuben noted, "knowledge of playing in front of audiences is a good prep for doing this work. I think that the more gigs that you've done, you learn a little bit more to read an audience." In both cases, we see the conversion of artistic to therapeutic knowledge, as noted by Petersson and Nyström (2011), in their study of developing music therapists. In this case, it is not only general musical knowledge that enables decision making, but also instrumental competency and performance experience.

The choice of music plays a key role in musical preparation. Practitioners commented on the necessity of knowing a bank of high-quality repertoire thoroughly, being passionate about the music they played and choosing music that could be adapted. Sophie stated, "We've got like a canon of repertoire that we use as starting points and… we feel really comfortable with that repertoire so… we know how we can then play with it and extend it." Practitioners said this enabled them to make decisions quickly, converting their musical experiences outside the healthcare setting into something relevant and useful within the decision-making process in the hospital. Participants placed value on the quality of musical knowledge and skills, as a basis for successful interactions in the hospital. Regarding the related field of music therapy, Hanser (2016) found a similar emphasis placed on the quality of music making. She quotes music therapist Mary Adamek: "High level musicianship paired with strong therapeutic skills creates a foundation for effective music therapy interventions leading to positive outcomes" (p. 856).

Experience working in hospitals

Making decisions requires drawing on previous experience. "Building experience" appeared frequently throughout the data, regarding how naturally practitioners made decisions and how at ease they felt in the environment, learning from previous hospital work. Sophie observed: "It's kind of an action research, you go in, you experience and then that informs the way you prepare for the next session."

Interviewing practitioners with varied levels of experience revealed interesting differences in their initial decision-making process. The difference in confidence in their practice between Sophie and Claire (most experienced to least) was apparent. Sophie described her detailed decision-making process when entering an interaction, talking of observing the "feel of the ward" and getting a sense of what is appropriate. On the other hand, Claire was guided by the experience of the hospital staff who knew the patients better, due to her apprehensions of getting something wrong. This suggests

that music-for-health practitioners become more confident at making their own decisions over time and are, like music therapy students, "learning through practice" (Petersson & Nyström, 2011, p. 9). The more experience music-for-health practitioners have, the more confident they become (Preti & Welch, 2013). For example, one participant described how she learnt to prepare herself mentally, emotionally and practically:

> It actually starts from even going back to when you arrive at the hospital… thinking about what kind of mood you are in, so that… you leave everything behind and your… mind is clear and open. So, even that process of preparation I think is very important, how you enter the environment of the hospital… Then it gives you time to get ready, get the instrument ready… all that kind of clearness, that ritual of preparation I think it's all part of this process of being ready. (Sophie)

Taking note and taking in

Information from observation was significant for the practitioners' decision-making process, not only whilst interactions took place, but also in their reflections after the sessions. In these ways, they absorbed what happened and used this to move forward in their practice.

Reading the moment

One term frequently used was to "read the room", the ability to take in the moment and decide how to respond musically. Reuben said, "I think a lot of it is almost a sense of reading the room... and then you try to spot individuals within that setting." Preti and Welch (2013) discussed "the constant attention musicians needed to 'decode' an emotional situation and 'translate' it into music" (Preti & Welch, 2013, p. 370). This process includes reading body language, sensing changes in emotion, and being aware of physical and verbal cues. Body language was particularly relevant for the participants. Sophie mentioned looking for small body movements: "they might turn their head slightly towards the music, they might open their eyes. They might start to move a hand or a foot." In Reuben's case, he talked of more emotive body responses, such as patients who made eye contact and those "who will not give eye contact or hide behind newspapers or phones… [or] somebody who looks a bit upset or turns their back on you." This level of awareness allowed him to interact with everyone accordingly and sensitively, perhaps drawing the more subdued patient into the interaction through the enthusiasm of the other. The ability to read body language has long been recognised as a key factor when communicating in all professions (Slovenko, 1998). This is essential in an environment, such as a paediatric ward, where many of the patients are non-verbal. Not only is this key for initially reading a situation, but also to continue communication during an interaction, by observing emotions, gestures and the sounds patients make (Hawley, 2018). Sophie explained:

> On approaching the bedside, really trying to see, is there a child who is maybe on their own or isolated or maybe looking bored that might be ready for some musical interaction? Does anybody in a bay look at us immediately and look curious?

Practitioners then determined whether music was appropriate at that time, whilst being aware of each individual in the room. These cues were not always positive, and Reuben mentioned how it was equally important to be aware of the people who did not want music. Similarly, Sheridan and McFerran (2004), even though focusing on music therapy, discussed similar opportunities of choice and control, where patients were given the option to engage with music or not. The practitioners spoke about processing this information to decide how to react and move forward with the interaction.

Reflection

Reflective observation allows practitioners to understand their current practice and improve for the future. All participants highlighted the importance of reflection, especially for making future decisions, having a support network and processing their experiences. Claire explained, "learning from the past to inform the future, it just makes every decision so much quicker." Reflection allows practitioners to examine their practice, note successes, learn from observation and create a basis for making future decisions. This corresponds to Petersson and Nyström's (2011) theme of learning through reflection. Sophie said, "to think about your practice, to think about why something worked, why it didn't work, how you felt at that time, how you engaged with other people, is definitely important in improving your work." Fiona described a cyclical connection between reflection and action as follows: "it's all very well and good sort of sitting and thinking about things for a long time but then, it's almost like you have to practice making decisions based on your previous reflections on the spur of the moment."

Reflection on self is another important aspect of this theme. Preti and Welch (2012b) researched the challenges musicians face in the emotional and stressful environment of a hospital, in particular the "risk of burnout and related causes" (p. 652). Their participants talked of physical exhaustion and emotional fatigue and how it impacted their work. The negative implications for musicians working in hospitals, such as the "burden of caring" (Edwards, 2016, p. 850) experienced by music therapists, should be understood and tackled. Self-care is self-evidently important; "it makes sense that in order to help others we must first help ourselves" (Radey & Figley, 2007, p. 210). In this study, Sophie mentioned allowing herself time before working in the hospital to get in the correct frame of mind. In addition, Fiona stated:

> Quite often I will just slip off to a play room or just wander down the corridor between interactions so that I can just have a little bit of head space, so you don't feel like you're just constantly running… and that's the only way really that I've managed to feel like I stay in the moment for each interaction.

Understanding self-preservation appears to be of utmost importance within this work. Many of the participants in the study by Preti and Welch (2012b) talked of having a break from hospital work for self-care. Being aware of one's emotions and the need to react accordingly runs parallel to being congruent in one's practice. There is a balance between emotional self-awareness and the need to be transparent with the patients (Greenberg & Geller, 2001).

Performance conditions

Even within a hospital setting, the practitioners were all aware of themselves as performers. The space they were in became a performance space. However, an awareness of the setting helped guide the decisions of the practitioner, determining what was appropriate.

Clinical setting

The paediatric hospital is an unpredictable and difficult environment for family, patients and staff (Edwards & Kennelly, 2016). This was noted by all practitioners; the complexity of the setting needed acknowledging in order to make appropriate musical and interpersonal decisions. The musicians learned their place within the hospital, as described by Sophie: "music is one element in the hospital… it might be quite a low priority element for the whole hospital, so… finding your place and that being strong there… can take time to develop." To help find this place, participants found it helpful to observe and listen to the staff because music-for-health practitioners are often not informed of a patient's situation before starting an interaction. Musicians also learn to transfer their skills (Hawley, 2014) to fit this unique performance space, where decisions are no longer only musical, but also based on the patients' needs and the clinical surroundings (Hawley, 2018). Aiding a medical intervention, as mentioned by Fiona, might require the musicians to play relaxing or distracting music (Preti & Welch, 2012a), whereas entering a play room might mean performing something fun and engaging. For the practitioners in this study this meant understanding the unpredictable ward environment, taking note of the clinical situation and demeanour of staff. Sophie and Reuben both commented on observing the monitors for oxygen levels and heart rate, reacting to changes as part of their decision-making process.

All practitioners were asked about how they make in-the-moment decisions in the clinical setting. The word "clinical" proved to be of great interest, with practitioners stating that they were unqualified to make clinical decisions. Fiona responded, "I'm not clinically trained so I wouldn't say I was making clinical decisions generally." Even though "Clinical decision making is a balance of experience, awareness, knowledge and information gathering" (NHS Education for Scotland, 2013), and this definition could be used to describe music-for-health practitioners' work, it must be acknowledged that musicians working in healthcare settings might not identify with this label. Some music therapists, such as Procter (2004), also actively use non-medical ways to organise and understand their work, which de-emphasise the clinical. In this regard, there is a strong resonance between music-for-health work and the ideals of Community Music Therapy (Stige & Aarø, 2012).

Spontaneity and intent

Intuitive, spontaneous and instinctive decisions play an important role when working in this unpredictable environment. Claire stated, "you never really know what's gonna happen and every session is completely different, and it's great but it's crazy." Instinctive decisions occurred as practitioners became more familiar in an environment. Claire added that "there are decisions that you don't even realise that you're making until you've made them… as it gets more instinctive you can kind of see if something isn't going to work very well." Sophie also commented on working with other musicians long-term:

> I suppose through working together for a long period of time, most of the time… we might… feel a shift together that we need to slow down or change the mood... That kind of working together I think is like an unsaid decision-making.

The performance setting is a particularly unpredictable environment, where change is frequent; therefore, spontaneity is needed in making quick decisions. All participants mentioned this as part of their work; for example, reacting to a child by copying their movements and emotions was a spontaneous action that practitioners employed. Participants in Preti and Welch's (2013) study also discussed the ability to be flexible in order to meet patients' needs, especially when they are non-verbal. Flexibility ran throughout participants' responses in the present study, regarding their intentions and reactions, including the idea that there was not just one way to make a decision. There was respect for fellow practitioners who made different, but equally effective, choices:

> Somebody else might go into a situation and maybe make a different decision and both outcomes might be equally effective… so it's not that your one way is the right way. (Sophie)

Practitioners all started with intentions, even if they diverted from their initial plan, as in studies of music therapy practice by Beer (2011) and Loth (2017). In this current study, Reuben spoke of musicians having a role to play in lightening the mood and creating a fun atmosphere, similar to the participants in Preti and Welch's (2013) study, who talked of needing a sense of humour and being entertaining. However, Fiona's intentions were the antithesis to this:

> I feel very... strongly that the music is not there to cheer people up, it's there as a reflection of what's going on in that moment. And the mood can change, can be helped by music but at that time I'll always try and fit the music to the mood, not to impose the mood on top of what's happening.

This view echoes the Iso Principle (Bunt & Stige, 2014), which relies on initially matching the patient's mood before intervening to change their affect. Similarly, in Baker's (2013) study, music was composed with patients to convey the emotions of the moment. Fiona developed her view by stating, "My intention… is always to bring music to the space and to see what happens. But that's the only intention I ever have when I go... to work." For Fiona, this intention underlay all others and never changed, all further intentions related to context. In this sense, her approach proceeded from musical actions to goals, rather than the opposite. These two possible ways of connecting actions and goals are outlined and discussed by Beer (2011).

Forms of communication

Communication through music and through interpersonal interaction was frequently mentioned by the practitioners as fundamental to decision making.

Musical presentation and choices

In an environment where verbal communication is not always easy or possible, music provides a place where "people can share emotions, intentions and meanings" (Hargreaves et al., 2005, p. 1). With the music prepared and chosen in a way that was flexible and had variety, practitioners then altered it to suit the situation. Music was predominantly directed by the child, similar to the findings of music therapist North (2014) who noted, "we continually respond to an individual's actions or vocalizations, no matter how small, seeking to give control over aspects of the music" (p. 780). This form of direction was noted by the participants in this study and took several forms: it could be through following the children's emotional state, but equally following the physical movements or sounds they were making. It could also mean playing music that suited one child, but then having to alter it quickly to suit the needs of another. Fiona described such an interaction:

> When I went into the room I had a piece of music which could have gone either way. I started off… at a moderate speed and quite a low level and then, immediately this boy ran up to me and so I sat down on the floor with him… he was just so excited to see the cello and the instruments, and so immediately in that little corner of that room the music came up… But then I'd noticed… there was another little boy who was on his own and was quite upset so, I then brought the music back down when I was leaving that corner and using the same music walked over to go and work with this boy, on a sort of different musical level.

Music is a tool to communicate with patients, especially through musical conversations: "Improvised musical interactions can help sustain communicative interactions without words" (Wetherick, 2014, p. 868). Petersson and Nyström (2011) stated that a thorough musical knowledge enables a conversion to therapeutic performance, especially with regard to improvisation. Practitioners in this study communicated through reacting to changes in the patient. Sophie suggested this may occur when "a child's got quite excited quite quickly so we might think… we just need to bring everything back a little." Practitioners found ways to reflect this change in their performance. They mentioned different methods for doing this, such as changing the key, melody, tempo, timbre and dynamics, sometimes using silence and ensuring the changes between musical styles were gradual, so the transition was smooth and the music mirrored the child's actions and demeanour. Hawley (2018) described the variety of repertoire needed to aid the communication process and the knowledge of how to change the music and why. The need to have an extensive knowledge of how to communicate through music is essential.

Interpersonal interaction

Communication also occurred through personal interaction between practitioner and child. Similar to determining a musical change, practitioners reacted to a change in a child's demeanour, interpreting their emotions by altering aspects such as their own body language, their position in the room or what they said. Thus, the patients' needs were communicated and reflected through the interaction, as Reuben described:

> If… I'd read that somebody was feeling very distressed I'd try and… dissolve away a little bit… move slowly backwards. Likewise, if somebody was reaching out, or if the readings look positive I would move forward.

Hawley (2018) wrote of "learning to read the signs of communication" (p.14), as it is important to note that communication is not only from the musician through their playing, but also from the patient reacting to the music. Many of the patients in a paediatric environment are non-verbal and Hawley described the importance of using facial expressions and body movements as a form of communication with a patient. Practitioners in this study mentioned the importance of approaching an interaction with care, also observing the use of verbal and non-verbal communication. Speaking to family and children at times was mentioned as being useful, as well as watching staff reactions and having eye contact with the child. Then, the role is to react to this information accordingly and communicate one's understanding of the situation. Sophie spoke of communication with a non-verbal child:

> The boy and I had little kind of mouth popping conversations… very subtle sounds at the bedside and there was this point where we felt we really had a conversation and he was very aware of us.

Regarding starting interactions, Loth (2017) described the difficulties that can arise, especially when meeting patients for the first time. The practitioners in this study decided by what means they should approach the bedside and allowed space for the child to react and guide the interaction. Being guided by the child and creating a reciprocal communicative flow relates to Sheridan and McFerran's (2004) findings that choice and control in music therapy leads to empowerment and improved quality of life.

CONCLUSION

This study aimed to explore how music-for-health practitioners make sense of decision making whilst interacting with patients in paediatric hospitals. In responding to the research question, the results express an understanding of decision-making through the following themes: (i) Building the foundations; (ii) Taking note and taking in; (iii) Performance conditions; and (iv) Forms of communication. These elements of practice interconnected and ran in parallel, grounding the practitioners' decisions and allowing them to draw on their previous musical knowledge, skills and experience. Participants also found meaning in their reflective process and how they read the moment during an interaction. They also discussed spontaneity in their practice and how the decision-making process developed through experience. This process included different types of decisions: in-the-moment decisions as an instant reaction, intuitive decisions that developed through experience and reflective decisions that were informed by previous practice.

The results give a detailed picture of the multiple areas of decision-making required for music-for-health practitioners. Although the data collected in this study are rich, having more participants, especially those with fewer than five years of experience, would have resulted in a more representative

sample. An area for future research would be to compare the decision-making process of practitioners at the very start of their careers to practitioners with a wealth of experience. This could help to outline what areas of training need to be developed for new practitioners to begin the decision-making process that the more experienced practitioners undertake. Additionally, the points raised by practitioners regarding their understandings of the word "clinical" highlights a potential area for further discussion, namely the use of terminology in music-for-health work and how this might relate to notions of professional identity.

Music for health is becoming an increasingly popular career path for freelance musicians (Petersson & Nyström, 2011) and this study has explored the process of decisions that can be transferred into practice for musicians who are making the transition into this work. It is hoped this might be particularly useful for practitioners at the beginning of their therapeutic careers and for experienced practitioners as a point of reflection. The emergent themes could be referred to in training new practitioners, to develop sensitivity to this aspect of practice from the outset, running alongside the work of Petersson and Nyström (2011), who explored the learning processes for early-career practitioners. This article may also have relevance to multi-disciplinary teams, allowing doctors, nurses and other hospital staff to understand decision-making processes in greater depth. In turn, this understanding may foster closer collaboration and better integration of music-for-health practitioners into healthcare settings.

REFERENCES

Artfelt (2020). *Artfelt: What we do*. https://www.tchc.org.uk/our-impact/artfelt.html

Avers, L., Mathur, A., & Kamat, D. (2007). Music therapy in pediatrics. *Clinical Pediatrics, 46*(7), 575-579. https://doi.org/10.1177/0009922806294846

Baker, F. A. (2013). What about the music? Music therapists' perspectives on the role of music in the therapeutic songwriting process. *Psychology of Music, 43*(1), 122-139. https://doi.org/10.1177/0305735613498919

Bangert, D., Fabian, D., Schubert, E., & Yeadon, D. (2013). Performing solo Bach: A case study of musical decision-making. *Musicae Scientiae, 18*(1), 35-52. https://doi.org/10.1177%2F1029864913509812

Bangert, D., Schubert, E., & Fabian, D. (2014). A spiral model of musical decision-making. *Frontiers in Psychology, 5*, 1-11. https://doi.org/10.3389/fpsyg.2014.00320

Beer, L. (2011). A model for clinical decision making in music therapy: Planning and implementing improvisational experiences. *Music Therapy Perspectives, 29*(2), 117-125. https://doi.org/10.1093/mtp/29.2.117

Breathe AHR (2020). Our programmes: Magical. Musical. Medical. https://breatheahr.org/our-programmes/

Bunt, L., & Stige, B. (2014). *Music therapy: An art beyond words*. Routledge.

Chaffin, R., & Imreh, G. (2001). A comparison of practice and self-report as sources of information about the goals of expert practice. *Psychology of Music, 29*, 39-69. https://doi.org/10.1177%2F0305735601291004

Creswell, J. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage.

Edwards, J. (2016). Training, education, and professional issues in music therapy. In J. Edwards (Ed.), *The Oxford handbook of music therapy* (pp. 847-852). Oxford University Press.

Edwards, J., & Kennelly, J. (2016). Music therapy for hospitalized children. In J. Edwards (Ed.), *The Oxford handbook of music therapy* (pp. 53-65). Oxford University Press.

Fancourt, D., & Finn, S. (2019). *What is the evidence on the role of the arts in improving health and well-being? A scoping review. Health Evidence Network Synthesis Report, No. 67*. Copenhagen: World Health Organisation. http://www.euro.who.int/en/publications/abstracts/what-is-the-evidence-on-the-role-of-the-arts-in-improving-health-and-well-being-a-scoping-review-2019

Great Ormond Street Hospital for Children, NHS Foundation trust (2020). Meet the play team. https://www.gosh.nhs.uk/wards-and-departments/departments/clinical-support-services/play/meet-play-team

Greenberg, L., & Geller, S. (2001). Congruence and therapeutic presence. In G. Wyatt (Ed.), *Congruence: Rogers' therapeutic conditions: evolution, theory and practice.* (pp. 131 - 149). PCCS.

Hallberg, J., & Silvermann, J. (2015). Staff perceptions of live classical music in an urban medical setting: A qualitative investigation. *Musicae Scientiae, 19*(12), 135-146. https://doi.org/10.1177%2F1029864915583375

Hanser, S. B. (2016). Music therapy training requirements. In J. Edwards (Ed.), *The Oxford handbook of music therapy* (pp. 853-874). Oxford University Press.

Hargreaves, D., MacDonald, R., & Miell, D. (2005). How do people communicate using music? In D. Hargreaves, R. MacDonald, & D. Miell (Eds.), *Musical communication*, (pp. 1-26). Oxford University Press.

Harrop-Allin, S., Hume, V., Fabian, J., Etheredge, H., & McCallum, M. (2017). "Humanising healthcare spaces": Report on the development and impact of a music collaboration between community music and Donald Gordon Medical Centre at the University of the Witwatersrand, Johannesburg, South Africa. *Muziki: Journal of Music Research in Africa, 14*(2), 55-80. https://doi.org/10.1080/18125980.2017.1379884

Hawley, R. (2014). Comment and opinion: Transferable skills: Enhancing the versatility of tomorrow's music educators. *Music Mark Magazine, 4*, 3-4. https://musicforhealth.files.wordpress.com/2013/02/mm-mag-e28093-issue-4-spring-2014-upload2-rncm-article.pdf

Hawley, R. (2018). Listen to a songbird sing: Musicians, creativity and the paediatric hospital setting. *International Journal of Community Music, 11*(1), 7-20. https://doi.org/10.1386/ijcm.11.1.7_1

Howat, R. (1995). What do we perform? In J. Rink (Ed.), *The Practice of performance: Studies in musical interpretation* (pp. 3-20). Cambridge University Press.

Kern, P. (2011). Evidence-based practice in early childhood music therapy: A decision-making process. *Music Therapy Perspectives, 28*(2), 776-723. https://doi.org/10.1093/mtp/28.2.116

Loth, H. (2017). Cacophonies of discord, moments of harmony: Managing multiple needs in short-term music therapy with triplets and their mother. *British Journal of Music* Therapy, *31*(1), 26-31. https://doi.org/10.1177%2F1359457517695273

MacDonald, R., Kreutz, G., & Mitchell, L. (2012). What is music, health and wellbeing and why is it important? In R. MacDonald, G. Kreutz & L. Mitchell (Eds.), *Music, Health and Wellbeing* (pp. 3-11). Oxford University Press.

Manchester University, NHS Foundation Trust. (2020). Play services. *NHS Online.* https://mft.nhs.uk/rmch/services/play-services

Merriam, S. & Associates. (2002). *Qualitative research in practice: Introduction to qualitative research.* Jossey-Bass.

Music in Hospitals and Care. (2018) Research. https://mihc.org.uk/about/research/

NHS Scotland, Education for Scotland. (2020) What is clinical decision making? *Effective practitioner* [Electronic Version] 1-7. https://www.effectivepractitioner.nes.scot.nhs.uk/clinical-practice/what-is-clinical-decision-making.aspx

North, F. (2014). Music, communication, relationship: A dual practitioner perspective from music therapy/speech and language therapy. *Psychology of Music, 42*(6), 776-790. https://doi.org/10.1177%2F0305735614552720

Oxford Living Dictionaries. (2018). Definition of clinical in English. *Oxford University Press.* https://en.oxforddictionaries.com/definition/clinical

Petersson, G., & Nyström, M. (2011). Music therapy as a caring intervention: Swedish musicians learning a new professional field. *International Journal of Music Education, 29*(1), 3-14. https://doi.org/10.1177%2F0255761410389659

Preti, C., & Welch, G. (2012a). The incidental impact of music on hospital staff: An Italian case study. *Arts & Health: An International Journal for Research, Policy and Practice, 4*(2), 1-13. https://doi.org/10.1080/17533015.2012.665371

Preti, C., & Welch, G. (2012b). The inherent challenges in creative musical performance in a paediatric hospital setting. *Psychology of Music, 41*(5), 647-664. https://doi.org/10.1177%2F0305735612442976

Preti, C., & Welch, G. (2013). Professional identities and motivations of musicians playing in healthcare settings: Cross-cultural evidence from UK and Italy. *Musicae Scientiae, 17*(4), 359-375. https://doi.org/10.1177%2F1029864913486664

Procter, S. (2004). Playing politics: Community music therapy and the therapeutic redistribution of musical capital for mental health. In M. Pavlicevic, & G. Ansdell (Eds), *Community music therapy* (pp. 214-230). Jessica Kingsley Publishers.

Radey, M., & Figley, C. R. (2007). The social psychology of compassion. *Clinical Social Work Journal, 35*(3), 207-214. https://doi.org/10.1007/s10615-007-0087-3

Reid, P. (2016). Music therapy for children and adolescents diagnosed with cancer. In J. Edwards (Ed.), *The Oxford Handbook of Music Therapy* (pp. 66-86). Oxford University Press.

Sheridan, J., & McFerran, K. (2004). Exploring the value of opportunities for choice and control in music therapy within a paediatric hospice setting. *Australian Journal of Music Therapy, 15*, 18-32. https://www.austmta.org.au/journal/article/exploring-value-opportunities-choice-and-control-music-therapy-within-paediatric

Slovenko, R. (1998). Understanding body language. *The Journal of Psychiatry and Law, 26*(2), 291-305. https://doi.org/10.1177%2F009318539802600212

Stige, B., & Aarø, L. E. (2012). *Invitation to community music therapy*. Routledge.

Sunderland, N., Lewandowski, N., Bendrups, D., & Bartleet, B.-L. (Eds.). (2018). *Music, health and wellbeing: Exploring music for health equity and social justice*. Macmillan Publishers.

Trondalen, G., & Bonde, L. O. (2011). Music therapy: Models and interventions. In R. MacDonald, G. Kreutz & L. Mitchell (Eds.), *Music, health and wellbeing*, (pp. 40-64). Oxford University Press.

Wetherick, D. (2014). Music therapy and children with a language impairment: Some examples of musical communication in action. *Psychology of Music, 42*(6), 864-868. https://doi.org/10.1177%2F0305735614547716

Wilson, G. B., & MacDonald, R. A. R. (2015). Musical choices during group free improvisation: A qualitative psychological investigation. *Psychology of Music, 44*(5), 1029-1043. https://doi.org/10.1177%2F0305735615606527

Wood, J., Sandford, S., & Bailey, E. (2016). 'The whole is greater'. Developing music therapy services in the national health service: A case study revisited. *British Journal of Music Therapy, 30*(1), 36-46. https://doi.org/10.1177%2F1359457516637324

Youth Music. (2017). Music in healthcare evidence review. *Youth Music, September 2017,* 1-16.

APPENDIX: INTERVEW QUESTIONS

1. How long have you worked as a music-for-health practitioner?
2. How long have you done this work in hospitals?
3. How long have you worked with children in hospitals?
4. Could you tell me about a memorable experience interacting with a patient?
5. How do you make sense of the initial decision-making process?

   <Prompt> For example, is there anything in particular you might look out for to guide your interaction?
6. (i) What sources of information do you use to make clinical decisions?

   (ii) How do you integrate these sources of information?
7. What decisions do you make when first going into a musical interaction?
8. Are any of these more important than the other?
9. How does planning and preparation help make in-the-moment decisions?
10. What might prompt you to decide to change how you play and interact during a session?
11. To what extent does your prior musical knowledge help guide your decision-making?
12. How do you decide what music is appropriate for the setting?
13. How do you know which of your skills you need to draw on for particular interactions?
14. How does reflection on previous practice help you make in the moment decisions? (reflection in action)

Ελληνική περίληψη | Greek abstract

Πώς οι διαδικασίες λήψης αποφάσεων των επαγγελματιών μουσικής και υγείας ενημερώνει το έργο τους σε παιδιατρικά νοσοκομεία

Jessica Tomlinson & John Habron

ΠΕΡΙΛΗΨΗ

Η παρούσα ποιοτική έρευνα μελέτησε τον τρόπο με τον οποίο οι επαγγελματίες μουσικής και υγείας [music-for-health practitioners] κατανοούν τη διαδικασία λήψης αποφάσεων στο πλαίσιο των νοσοκομειακών παιδιατρικών κλινικών στο Ηνωμένο Βασίλειο. Παρόλο που προϋπάρχουσες μελέτες έχουν διερευνήσει τις δεξιότητες που αναπτύσσουν οι επαγγελματίες και πώς αυτές συσχετίζονται με τα αποτελέσματα και τα οφέλη της μουσικής για την υγεία, αυτό το άρθρο περιγράφει συγκεκριμένα τη διαδικασία λήψης αποφάσεων και το πώς οι επαγγελματίες αντλούσαν από ήδη κατακτημένες δεξιότητες. Τέσσερις επαγγελματίες μουσικής και υγείας, όλοι εκ των οποίων εργάζονται σε νοσοκομειακές παιδιατρικές κλινικές του Ηνωμένου Βασιλείου, τοποθετήθηκαν σχετικά με τις εμπειρίες τους στη λήψη αποφάσεων. Οι συνεντεύξεις ήταν ημι-δομημένες. Τα δεδομένα αναλύθηκαν θεματικά και προέκυψαν τα παρακάτω θέματα: (α) χτίζοντας τα θεμέλια, (β) παρακολούθηση και κατανόηση, (γ) συνθήκες της μουσικής εκτέλεσης, και (δ) τρόποι επικοινωνίας. Η μελέτη απευθύνεται σε επαγγελματίες μουσικής και υγείας που βρίσκονται στο ξεκίνημα της καριέρας

τους, προσφέροντας τρόπους να κατανοήσουν τη διαδικασία λήψης αποφάσεων. Μπορεί επίσης να φανεί χρήσιμη σε πιο έμπειρους επαγγελματίες ως προς το να κατανοήσουν και να αναστοχαστούν σχετικά με τις δικές τους επαγγελματικές διαδικασίες λήψης αποφάσεων και να έχουν μία τεκμηριωμένη βάση όταν εκπαιδεύουν νέους επαγγελματίες. Με επίκεντρο το πλαίσιο του παιδιατρικού νοσοκομείου, αυτό το άρθρο μπορεί ακόμη να έχει διεπιστημονικές προεκτάσεις στο να βοηθήσει το ιατρικό, νοσηλευτικό και άλλο προσωπικό να κατανοήσουν καλύτερα την πρακτική της μουσικής για την υγεία.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ
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APPROACHES

ARTICLE

"Music is something to cling to; a lifeline" – Music listening in managing life with chronic pain and anxiety

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ABSTRACT

This article presents a single case study that explores the role of music listening in managing life with chronic pain and anxiety. Engagement in music can reduce the subjective experience of pain and can be a valuable tool for self-regulation and emotion management. However, engagement in music and the effects deriving from it are highly individual and multifaceted; therefore, it is difficult to make generalisations about the role of music in physiological and psychological functioning. Instead, the present case constitutes an idiographic research approach, based on an understanding that in-depth, qualitative research on individuals' personal experiences may be fruitful to broaden our knowledge base. Employing an interpretative phenomenological analysis, this article presents a rich, singular case of a woman suffering from chronic pain related to childhood trauma. An in-depth interview explored the informant's daily music listening habits and how these related to her experiences of physical and mental pain. The informant listens to music to dull the experience of physical pain, to distract her from psychological distress, to keep her in the here-and-now and to represent her healthy self. This case can add to our understanding of music listening as a holistic life management skill in coping with chronic pain and trauma, and stresses the interrelation between body, emotion and cognition.

KEYWORDS

music listening,
chronic pain,
migraines,
trauma,
coping,
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INTRODUCTION

This article explores a rich and singular case of a woman suffering from chronic pain, related to childhood trauma, who uses music listening for management of that pain. We know that music is often used to manage physical pain (Lee, 2016) and psychological distress (Skånland, 2013a; Vist & Bonde, 2013), and that individuals use music actively to regulate emotions (Thoma, Ryf et al., 2012; van Goethem & Sloboda, 2011) and bodily states (DeNora, 2000; Ruud, 2007; Skånland, 2012). Music is further used in pain management both in medical settings (Bernatzky et al., 2011; Vaajoki et al., 2011) and by individuals in everyday life (Linnemann et al., 2015; Mitchell et al., 2007).

While engagement with music can mitigate the subjective experience of pain and offers a valuable tool for self-regulation and emotion management, it is a highly individual and multifaceted experience and effects are variable. It is difficult to devise general laws regarding the role of music in physiological and psychological functioning (McFerran, 2016; Thoma, Scholz et al., 2012). On the other hand, in-depth qualitative research on individuals' personal experiences may broaden our understanding of music's role, as it allows for more exhaustive exploration of these subjective and often complex experiences.

This article presents findings from an in-depth interview that explored an informant's daily music-listening habits and their relation to her experiences of chronic pain and emotional difficulty stemming from childhood trauma. By thoroughly engaging one woman's situation, this article gains significant insight into how music functions as a coping resource on an individual level and emphasises the interrelation between body, emotion and cognition.

EXPERIENCING PAIN: AN EMBODIED UNDERSTANDING

Biomedicine has been criticised for its fragmentation of the human body into seemingly discrete parts and, more generally, by its separation of the body from the mind (Blaxter, 2004; Kirkengen & Næss, 2015; Kirkengen, 2018), which has given rise to an understanding of medicine and psychology as different sciences. Although a more holistic understanding of health and human experience has accompanied the arrival of the social model of health (Antonovsky, 1979; Mæland, 2016) and the biopsychosocial model (Engel, 1977), Kirkengen (2018) indicates a continuing tendency to seek redress for bodily responses such as chronic pain through biomedical procedures. In this article, I will propose a holistic understanding of human processes and experiences—one that views bodily and mental processes as parts of the same system. This links to the biopsychosocial (Meints & Edwards, 2018) and phenomenological understanding of pain (Kirkengen, 2017, 2018).

Merleau-Ponty (2002) views the human as a 'bodily self' in sensory interaction with the world. He claims that the human exists in the world as a *lived body*, not a thinking consciousness, revisiting the separation of body and mind that has dominated Western thought since Descartes in the seventeenth century. Kirkengen and Næss (2015) subscribe to Merleau-Ponty's perspective when they explore how violated children become sick adults. When it comes to chronic pain, this notion of the *lived body* supplies a crucial framing device. Any form of trauma, also psychological violation, will prompt a physical response, such as inflammation, tension and pain (Kirkengen & Næss, 2015; Van Houdenhove et al., 2009).[1] Kirkengen (2018) therefore unambiguously states that the so-called division between physical and psychical trauma is an illusion.

In order to fully understand human functioning, then, it appears fruitful to cultivate a phenomenological approach, where we view the human being as a *whole person*, and body and mind as aspects of the same (human) system.

[1] Kirkengen (2018, p. 2) notes: "[…] all ways of being in the world that are experienced as being continually and existentially threatened engender processes on the physiological level in the human body that affect the most central bodily systems for safeguarding viability and vitality. These include, among others, the hormonal, immunological, and central nervous systems, the systems for regulation of glucose, lipids, and minerals, and the autonomous nervous system regulating sleep, breath, digestion, muscular tonus, and body temperature."

BACKGROUND: MUSIC, PAIN AND SELF-MANAGEMENT

While several studies on music and pain perception have been conducted within experimental or medical frameworks (Bernatzky et al., 2011; Hsieh et al., 2014; Mitchell & MacDonald, 2006, 2012; Vaajoki et al., 2011), those discussed below deal particularly with daily music listening and chronic pain.

Through a survey investigation of the effects of music listening on chronic pain (n=318), Mitchell and colleagues (2007) found music to be an effective distraction, which could reduce both the experienced intensity of the pain and the negative affects which accompany it. The authors identified positive effects of daily music listening on the general quality of life of participants with chronic pain. The respondents who listened most frequently and invested most profoundly in the music seemed to benefit the most.

Linnemann and colleagues (2015) conducted another study on daily-life music listening and chronic pain with a group of thirty patients with fibromyalgia syndrome. Using an ecological momentary-assessment design, they found that music listening increased the participants' perceived control over their pain. The effect was most pronounced when music was listened to for activation or relaxation.

Gold and Clare (2012) conducted interviews with eleven people living with chronic pain in order to explore the role of music listening in their experience of that pain. Several of the informants experienced reduced involvement with and enjoyment of music as a consequence of living with chronic pain, yet it still appeared to be a viable self-management strategy. It could improve their emotional state and distract from the physical pain, while also activating and motivating them to move and exercise. Music could also offer a connection to memories of a former, pain-free self.

In sum, music listening appears to have a beneficial impact on chronic pain, particularly thanks to perceived control, attendant enjoyment and improvement of emotional state. Coping strategies that appear most viable include distraction, relaxation and activation (Gold & Clare, 2012; Linneman et al., 2015; Mitchell et al., 2007). Importantly, self-selected music is the most effective form of music in this context (Mitchell et al., 2007).

We know that people with chronic pain are significantly prone to depression (Berrahal et al., 2017; Saariaho et al., 2013). When approaching the subject of music and chronic pain holistically, we must therefore acknowledge music's role in coping, self-regulation and emotion management (Baltazar & Saarikallio, 2017; Saarikallio, 2011; Schäfer et al., 2013; Skånland, 2011, 2013b; van Goethem & Sloboda, 2011). Affect regulation is a crucial aspect in depression, alexithymia and general well-being (Grewal & Salovey, 2006; Larsen & Prizmic, 2004). Among a variety of tactics for affect regulation, e.g. exercising, eating, calling a friend, or watching TV, Thayer and colleagues (1994) found music to represent a remarkably successful tactic in this regard.[2] Notably, music is used for the regulation of both affect, energy levels and tension (Thayer et al., 1994).

In a mixed-methods study with participants recruited from a university in the UK, van Goethem

[2] I use van Goethem's (2010) framework for affect regulation, which includes goals, tactics, strategies and mechanisms. Music listening can be used as a tactic to achieve the affect regulation goal (e.g. enhance happiness), while strategies explain why the tactic is used (for e.g. distraction, introspection or coping). This framework also makes sense for pain management, where distraction, relaxation and activation would be defined as strategies.

(2010) found that participants used music listening more often, and for a wider range of strategies, than any other affect regulation tactic. Common strategies discerned by van Goethem (2010) and Saarikallio (2011) include distraction, mental work (introspection, rational thinking), relaxation and venting. While Saarikallio (2011) notes similar conclusions in other studies, she also wonders whether individual differences exist in these strategies based on personal factors. By analysing a single case, it has been my intention to explore a compound, individual experience that may reflect a more general, human experience. I will present findings from the interview after briefly outlining the method employed.

METHOD

Participant

The participant in the study is a woman in her early thirties who lives with chronic migraines and has dealt with psychological challenges since childhood. She has participated in physical therapy and conversational therapy, but not music therapy. She is an urban citizen who was living alone at the time of the interview. The informant in question was asked to participate through a mutual acquaintance – a friend – based on a strategic choice: it was known to me that she was living with chronic pain, but I knew nothing about her music listening habits. It appeared fruitful to me to explore her lived experiences as a case on the matter. Interviewing ‘a friend of a friend’ does however require some ethical precautions. I will reflect on these issues below.

Design

The research was designed as a single case study. Interview was chosen as an appropriate method because I wanted to learn about the informant’s real-life experiences with music, and about the meaning of music in her life. Qualitative methods are a fruitful means of engaging the subjective meaning of everyday experiences (Flick, 2006; Kvale & Brinkmann, 2014). The qualitative interview provided me with a comprehensive and detailed understanding of the informant’s personal experiences and allowed me to both clarify and follow up on her responses on the spot.

The interview, which lasted for ninety minutes, followed a semi-structured framework and focused on the informant’s everyday music listening in dealing with her life challenges. The questions concerned her listening habits, her reasons behind her choice of music and the ways in which music listening affected her emotionally and physiologically. The informant was very articulate and spoke quite freely about the issues raised by our conversation. Trustworthiness in the interview was tested via interpreting questions (Kvale & Brinkmann, 2014), which involved rephrasing an answer and trying to clarify it, as well as via returning to certain topics several times during the interview and summarising my understanding of the informant’s statements at the end of the interview.

In presenting a single case, this article intentionally challenges the notion of the ‘anecdotal’ as a non-scientific or invalid method of knowledge production (Kirkengen, 2017). Single case studies fit particularly well within interpretative phenomenology, as they allow for in-depth learning about a particular person and exploration of connections within the single account (Smith et al., 2009). Doing a single interview as such allowed me to thoroughly explore the informant’s real-life experiences, and

the fact that she was highly reflective about these experiences added to the method's success.

Analysis

Focusing entirely on one story allowed for a thorough exploration of multiple and intertwined aspects within the single case. Interpretative, phenomenological analysis was considered a useful analytical approach, as it advocates the case study as well as a holistic framework (Smith et al., 2009).

Using Interpretative Phenomenological Analysis (IPA) (Smith et al., 2009), the full interview was transcribed verbatim, then analysed according to emerging themes. Thematic clusters were interpreted according to a phenomenological hermeneutic tradition and within the frameworks of embodiment and self-regulation theories. The emerging themes were *music listening as a coping tactic, music as painkiller, music as distraction, music as a trigger, music and the here-and-now,* and *music and identity.*

The approach comprised a double hermeneutic of sorts, because the analysis required that I tried to make sense of the informant trying to make sense of the role of everyday music listening in her coping with experiences of pain and trauma (Smith et al., 2009). As pointed out, IPA is concerned with thoroughly exploring the particular case in question (Smith et al., 2009). In line with this approach, I wanted to know, in detail, what the experience is for *the informant*, and what sense *the informant* is making of music in her life, as we will see below.

Ethics

Ethical approval for the study has been given by The Norwegian Social Science Data Services. The informant was given information concerning the purpose of the interview before she gave her free consent to participate. She was further informed that participation was voluntary, that personal information about her would not be stored, and that all data material would be anonymised. She was also informed that she could withdraw from the study at any point without any consequences on her part. The informant will be presented below as 'Laura'.

Inviting a 'friend of a friend' to participate in a research interview requires additional ethical reflections. There is a risk that the informant agreed to participate and speak of her personal experiences to avoid letting me down. As a means to reduce this risk, I asked the informant for her consent to participate prior to the interview *and* prior to the publication of the results in an aim for a genuine free consent as well as the opportunity for her to withdraw. Second, I strived for a sensitivity in the interview situation. I allowed the informant to speak as freely as possible and tried to be sensitive to her cues and directions in our conversation. The informant was further given the opportunity to read excerpts from the interview used in publications, and she has read and approved the results section of this article prior to publication. These measures are also believed to add to the trustworthiness of the findings.

RESULTS: MUSIC AS A COPING TOOL TO DEAL WITH LIFE

Laura struggles with migraines, as well as childhood trauma. For many years, the migraines were chronic. Now, she normally suffers a migraine three or four days per week. The pain evokes disturbing

memories and sensations that are related to a period in her life which she describes as hopeless, and which therefore trigger anxiety. Laura has been in therapy for many years, trying to deal with these struggles. She describes music as a tool which helps her to cope with the physical pain of the migraines, as well as the anxiety that they evoke:

> I'm in therapy to acquire tools to somehow deal with the everyday. And music can be such a tool, like I have in a way put together my own tool—it's obviously something I haven't thought about, but after this conversation I realise that I use it actively—and music is a tool that helps me deal with life, and to cope with memories and trauma.

Below I will explore further how Laura uses music and how it helps her.

Music listening as a coping tactic: 'I *always* put on music'

Laura describes her music listening as constant, at least when she is at home:

> I *always* put on music, so to speak. I can't really cope with being in silence. I think that can be demanding when I'm at home.

Laura mainly listens to Spotify, and often chooses predefined playlists that she adjusts to her liking. She explains how she can create playlists according to mood or season, such as "autumn" or "sleep", or search among the predefined playlists such as "sunset" to find music that 'matches' her state of pain.

The main reason she listens to music is because it helps her to focus on something other than her pain and her own thoughts, as will be explored in the sections below. She explains that there are other tactics that could be of use, such as meeting people or watching TV, but the physical pain of the migraines forces her to relax and often lie still with her eyes closed. In those situations, music is the most available coping tool:

> Being at work helps, because then I have to be here-and-now, but the most difficult thing is often to be alone and at home. Therefore, the music—well, you could have the television as well, but that demands a different focus—and the good thing about music is that you can have it with you. And I'm sometimes too sick to watch TV, and I need to lie still and close my eyes.

Laura is clearly impacted by her migraines, as well as her personal history. She feels as though the conditions of her existence are invisible to others, and this can make it hard for her to be around people even though she considers herself an outgoing person. Thus, in all contexts, not only when she is by herself, she finds that music can help her in dealing with both physical and mental distress:

> I can often find it difficult to be social and constantly fighting a battle no one else knows about. And then having music in the background can be liberating in a

> way. Often, I can find it intense to sit and talk and not have anything else to focus on, because then my thoughts... […] Often, the pain is so prominent that I feel I'm two places at the same time, and that is demanding. […] Music then becomes a support that helps you focus on something else.

Music helps Laura to settle down and to shift her focus productively, both when she is alone and when she is with other people. It is a primary coping tactic when she is in pain, because tactics such as watching television seem too demanding.

Music as a painkiller: 'It's a little like earplugs'

Laura takes medicine for the pain, but it is not always sufficient. Music then allows Laura to focus on something other than the pain; she describes how it dulls the pain the way earplugs mute noise:

> The music works a little the same way that you have medicine to make you sleep—earlier, when the pain was chronic and I was in pain 24/7, then [the medication] worked the same as if there's noise and you put in earplugs, then you can still hear the noise, but you have created a space that makes you able to relax—and that's how the pills worked—that the pain was still there, but with a little distance, so I could relax enough to fall asleep. And that's how the music works when I'm in pain. Like today, when no medicine works, then I kind of have to realise that I've lost the battle against the pain today, but then I need to somehow create a space to endure, I need to shift focus. […] The music becomes a rescue […] because it creates a kind of protection between the pain and me, to gain a little distance, even if you still feel it.

Music can create a separation between Laura and the pain, allowing her to better endure it. She compares the music to sleeping pills and earplugs in its ability to shield her. Music does not fix the problem, she says, but it can function like a painkiller:

> I think it [the music] is a good tool. It's a little like earplugs, so it becomes a tool, without becoming a solution, if you understand. I don't think the music can change anything in me, specifically, but it can work like a painkiller. It doesn't fix the cause of the problem, but it can dull, a little like an antipyretic, so it can help to reduce the flow of thoughts.

The pain can be overwhelming and Laura experiences it as filling her entire body and even the whole room. Music opens a space for her, she says, where she can be in peace, while the pain is left on the 'outside':

> You become so aware of your body when you're in so much pain. […] The pain can almost fill the whole room. Then the music comes and kind of puts a veil around me, and it capsules me in, perhaps, and the pain can be on the outside. It's as though I become really inflated when I'm in pain—I become a giant air balloon, in a way, which fills a really, really big space. I'm not always able to

> comprehend that I can be in so much pain—it's just little me, I mean, that it's possible to feel so much just in a body. And then I think it's the same earplug function, it [the music] comes between. So, then the pain becomes like the noise outside of the house. So, I get a little peace in here.

Listening to music, in other words, transforms her experience of pain. Laura describes the experience of listening to music as enjoying protection from the pain.

Music as distraction: 'Music stops the flood of thoughts'

For Laura, as mentioned, the physical pain of migraines is linked to disturbing thoughts and a general feeling of hopelessness:

> For me, the most difficult part of living with this pain is that often—when I'm less ill, in a way—is that I have so many bad memories linked to being ill. So, the migraine can trigger a whole lot of reactions. And then I've maybe had to turn to the music to try to stop the flood of thoughts that emanate. For me, it can function a little like meeting someone, so that I have to talk [to them]. You don't always have that option, and if you need to be home to try and relax, then the music is what can help stop that stream of thoughts—but then I can't have associations to it from before.

The music functions first as a painkiller but also as a distraction: "Normally the pain comes first, and then the thoughts, so the pain is the problem, but the hopelessness that is linked to it, that's hard to separate", Laura says. When music dulls the pain, the thoughts also let go a little. Music then helps to break the thought patterns Laura describes as 'catastrophic', which are triggered by the pain. Notably, Laura demands *new* music that does not arouse associations in her:

> And often that desperation you have when you're in pain, the only thing you think about is that you want to be pain free. And like today, when I've taken all the medication and there is no more, I'll need to listen to new music. I really need that distraction. Then I'm probably a little desperate, because nothing works, and then new music, at least if I find a song that really hits, then to listen to that over again can be very liberating. You get a little distance.

Music as a trigger: 'They say the senses are powerful in re-experiencing trauma'

Laura prefers *not* to listen to well-known music to distract her from her distress:

> I mostly enjoy music I haven't heard before, or that I recently discovered. I can enjoy it for a while, but then I soon grow tired of it. They [the songs] create a mood or give pleasure until I know them, and then they don't work anymore. I think that's important to me, that I don't know them, because then they absorb my concentration. But if I know how they go, I can listen and think about a lot of other things at the same time.

When the music becomes well-known, it does not demand the same amount of attention and therefore loses its effectiveness. The purpose of Laura's music listening, after all, is to focus on something other than her distress.

Relatedly, music from Laura's youth evokes particularly painful emotions from that time in her life. Because it is such an efficient trigger, Laura avoids the radio, for example, in order to maintain control over what she hears:

> I have trouble listening to the radio because then suddenly they play a song, and I connect songs to incidents in life extremely quickly. Like on the radio on the way to work the other day, they played 'Don't speak', and I'm right back in junior high school, and I see the whole setting. [...] I don't normally have nostalgic memories to music—it's more flashes of memories that you don't want.

Laura explains that it can be challenging to be in situations where she is not in control of the music:

> They say the senses are very powerful in re-experiencing trauma, and I think music is a strong link for me, more than smell, I think. And when I heard that No Doubt song, I had to change channels—I can't take it. And sometimes that happens when I'm with friends or I'm out somewhere—'oh please, don't make me [listen to this]'. I can get angry at some songs [...], because they were in the top ten when I wasn't okay. Even if nothing bad happened in those situations, they represent a period of my life.

Instead of being a nostalgic mnemonic for Laura, music brings back disturbing memories or sensations from her past. Also, Laura works actively to stay in the present, as we will see below.

Music and the here-and-now: 'Get my brain to understand that I'm in the present'

One of Laura's challenges is to stay present in the here-and-now, even while dealing with great physical pain. Her problem is that the pain evokes sensations and memories from her past, and therefore triggers anxiety. She explains:

> I believe that a lot of what I'm working on is to manage to believe, or to get my brain to understand, that I'm in the present. Because when you're in pain three or four times a week, then that pain is very recognisable, and then often the problem is that once the pain appears, it puts me back in a situation when I'm in a lot of pain, and life was completely hopeless. And therefore the pain, it's exactly the same as before, but my life is not the same.

Laura therefore works actively on convincing herself that she is in the present year, in the current part of her life. As a way of staying in the present, Laura turns to new music, as mentioned:

> Q: Can you explain what you mean when you say that the music makes you more present here-and-now?
>
> L: Yes, and that's why it's important that it's something new, because if I put on music I have heard before, it will connect to old stuff, while new music that I don't associate with things becomes a kind of confirmation of the sound in the room, precisely to say that this is happening here and now, you haven't heard this before, you can create associations, but they will be new ones. And then you can kind of recreate your past history.

By listening to new music, and thereby managing to understand – mentally and bodily – that she is in the present, Laura avoids being pulled back to old traumas and sensations that trigger anxiety. Music then appears as a healthy coping device, and music listening becomes a life management skill for Laura.

Music and identity: 'The music is something that is me'

Laura explains how she struggles to hold on to her identity and sense of self when she is in so much pain. The music becomes a lifeline, she states—something to cling to when she would otherwise be drowned in the hopelessness:

> You erase your identity. You're just sick, and that's something I think people don't do when they're only sick once in a while—I don't lose my identity when I'm down with fever for a week; then, I don't lose myself. But that happens with the pain because it's chronic, and I most likely will never escape it, so there's something hopeless in it. I know that this is my life, and this is how it will stay, and those thoughts are so scary. And that's where the music helps. [...] It's just about the musical aspects, the music, it's something to cling to. A lifeline.

For Laura, music represents and connects with a part of herself that is not sick. She listens to the same music whether she is sick or well in an effort to sustain positive associations with it and remain in an optimistic present:

> I think that's what's nice also: it [the music] is something that is me, and that's not linked directly to being sick. Music is something safe, because it's the same when you're healthy. That's why I don't listen to different music when I'm healthy and when I'm sick, because then I can create positive associations when I'm well and connect them to stuff that is here and now. And then to listen to that when I'm sick helps me to not disappear into old stuff.

Laura describes how the migraines *damage* her sense of self while music *supports* her sense of self:

> I think it's important to me that the things I like don't differ when I'm well and when I'm sick. [...] So the taste in music doesn't shift. And it's important to get that effect—that it's something else, that it's something that's me independently.

> Because that's what I find difficult about being sick so much of the time, that it's a very big part of me that I strongly dislike, that feels like an invasion of me, an exhausting, destroying force. Then to have the music, it becomes a support to me during that phase—that this is something that represents you and that you like. Because the danger is, you lie on the couch, you don't look good, right, you lose a part of yourself, when you should be out meeting people and being affirmed, but instead you're left to yourself.

Living with chronic pain makes Laura feel like she is losing herself in herself, and she yearns for the validation of other people. Positive associations with music ease this loneliness and existential dread, making the music a lifeline in managing chronic pain.

DISCUSSION

In the discussion of the results, I wish to maintain a link between the broader themes and Laura's narrative, in an effort to bring Laura's experiences to the core of a more theoretical reflection. In doing so, I relate to Smith, Flower and Larkin's understanding of the 'insightful case study' that can take us into the universal in that "it touches on what it is to be human at its most essential" (Smith et al., 2009, p. 38). Laura's case may here be understood as a mirror to a more general human experience, as "everyone carries a minimum of everyone within themselves" (Schleimaker, 1998, p. 92).

Music as a life management skill

Laura has obviously developed music listening as a life management skill (Aldwin, 2007), although she seemed to not be fully conscious of this prior to the interview. As seen in previous research on daily music listening and chronic pain management (Gold & Clare, 2012; Linneman et al., 2015; Mitchell et al., 2007), distraction, relaxation and activation were presented as the most viable coping strategies. Laura mainly uses music as a distraction from her distress, but it also allows her to relax, which recalls these findings. It is worthwhile to note how distraction and relaxation are described in the literature as helpful strategies in coping with the subjective experience of pain, and also as prominent strategies in studies on musical affect regulation (Saarikallio, 2011; Saarikallio et al., 2017; van Goethem, 2010). This perhaps points to the interrelation between body and mind, and illuminates bodily and affective regulation as holistic actions. For Laura, the music does indeed distract from the physical sensation of pain as well as the distress accompanying it. This merges into her experience of music as earplugs; it dulls, distances and distracts from her overall painful existence.

Traumatised memories

In an earlier interview study (Skånland, 2012), I found that music from one's past was particularly important, because of its specific nostalgic value. This music becomes a mnemonic, which merges music into the listener's identity constructions and sense of self (Ruud, 2013a; 2017). For Laura, however, music from her youth evokes painful emotions and she does her best to avoid it. Laura herself

emphasises her efforts to stay in the present and explore *new* music to sustain a health-giving sense of 'here-and-now'. We can understand her experiences in relation to how a person's memory functions differently in distant after-effects of trauma; because the episode is not cognitively processed, traumatic experiences will often not be stored as conscious and verbal memories, but remain instead as sensory reminiscence (Axelsen & Wessel, 2006; Kirkengen & Næss, 2015). When these experiences are aroused by a present-day trigger, they will not be recognised as a *memory.* The sensory experience will not represent something from the past but something that is happening *here and now,* and will possibly trigger reactions involving fear, pain, anxiety and so on (Kirkengen & Næss, 2015). It is obvious that music can trigger such sensory reactions in Laura, evoked by past trauma. When the sensory experience is aroused, she loses her presence in the *now* and literally re-experiences the event as if it is still happening (Axelsen & Wessel, 2006). The traumatized person can struggle with being in the present, as we have seen in Laura's narrative. It is therefore vital for her to seek out music that does not represent anything from her past.

However, in addition to music, the physical pain also functions as a trigger of past trauma for Laura. She explains how she must actively resist being pulled back in time by the sensory experience of the pain. By listening to new music and creating new associations to it, Laura purposefully uses the music to stay in the present. By listening to this music when she has a migraine, then, Laura manages to convince her brain and body that she is in the here-and-now. We thus see how Laura employs music as a tool to deal with her 'traumatised memory' (Axelsen & Wessel, 2006).

A healthy identity

Ruud (2013a; 2017) shows how music as a mnemonic is connected to an individual's identity. While Laura rejects music as nostalgia, she nevertheless positions it at the centre of her identity as a *healthy, whole* person. This experience is reflected in qualitative research on music in pain management (Gold & Clare, 2012). Whereas the informants in Gold and Clare's study (2012) said music could evoke an earlier, healthy self, Laura wants music to convince her that she is something *more* than her pain. She does this by listening to the same music when she feels well and when she is ill. In creating positive associations to the music when she is well, Laura consciously conditions music to represent her healthy side. Music then offers her something to cling to when she might otherwise be overwhelmed by hopelessness.

Moreover, Laura describes how the music can confirm her as a whole person. We can understand a person as a social self (Burkitt, 2008), who needs validation from others to form a sense of self and experience coherence in life (Trondalen, 2016). The experience of self becomes possible in or through the interaction with the other. In order to become ourselves, then, our initiatives must be met and responded to by others (Binder, et.al, 2006; Burkitt, 2008). For Laura, however, the pain prevents her from meeting people who could normally give her this response. Music then becomes a valuable 'other' that offers this affirmation, and helps Laura remain a healthy sense of self. The informants in Gold and Clare's study (2012) also described music as a companion that would help them feel less lonely. Because individuals living with chronic pain are easily cut off from their social world, music here offers a vital sense of connection.

Musical competency

Ruud (2013b) suggests that musical competency will enhance the health potential of music, whether it involves musical training, informed interest or skill. While Ruud acknowledges that we need more data to fully comprehend the role of one's musical background in one's music-related self-management or self-care, I believe Laura's account adds an interesting perspective here. Her competencies are not related to her familiarity with the music she listens to (or to musical skill as such), but rather to her nimble awareness of the importance of *avoiding* certain music. When she considers specific musical genres or 'moods', for example through Spotify's pre-defined playlists, she actively privileges unknown music to most successfully gain what she seeks: distraction from pain and distress. The question is, then, how should we define 'skill' or 'competence' in this context? Laura does indeed have knowledge of musical genres and musical moods, allowing her to avoid certain music and embrace other. Thus, we should understand musical competence here as the ability to differentiate between engagement in music that reinforces well-being and music engagement that relates to measures of ill-health. This would be in line with Saarikallio, Gold and McFerran's (2015) notion of healthy and unhealthy music listening.

A holistic life management skill

"Like pain, the power of music may be related to its operating simultaneously on multiple levels", Gold and Clare note (2012, p. 546). Laura's narrative shows us how music can be used in multifaceted ways to cope with physical and mental pain. We have seen how Laura listens to music to dull the experience of physical pain, to distract her from psychological distress, to keep her in the here-and-now and to represent her healthy self. These appear essential, yet complex and intertwined aspects of managing life with chronic pain (Ferreira-Valente et al., 2014; Meints & Edwards, 2018; Pothoulaki et al., 2012). Laura is in this world as a *lived body* (cf. Merlaeu-Ponty, 2002), and music is integrated in her *sensations* of self and the world. Her sensations of pain, past trauma, the here-and-now, her sense of self and her sense of self in relation to the world cannot be separated as individual experiences. If we view Laura's use of music listening in self-management from a phenomenological perspective, we see instead how the different aspects of her experiences are all parts of a holistic strategy for managing physical and mental pain, which are themselves aspects of one and the same experiential trauma.

CONCLUDING REFLECTIONS ON A FRAGMENTED LANGUAGE

When approaching the subject of experiences of pain, I have found myself in the dilemma of presenting the 'whole' (Laura's lived experiences) while simultaneously structuring a presentation of these lived, holistic experiences ('the whole') in a text like this. Our lifeworld does not necessarily fit within defined themes or categories, but it is nevertheless necessary to structure these lived experiences when we want to present them in a comprehensible manner. Our language is further built on categories, which can be difficult to circumvent. My intention has been to apply a phenomenological approach and embodied understanding of the present case of childhood trauma and chronic pain. The aim has been to better understand the impact of music listening as a coping resource in pain- and self-management, while avoiding a fragmentation of this subjective experience. However, I have wanted to also, in line

with a phenomenological approach, base the analysis on the experiences of the informant. I have therefore chosen to incorporate her personal concepts and categories in my presentation of her experiences. In our interview conversation, she would speak of the physical pain, her thoughts and the trauma as different categories, although she said that these are "hard to separate." Hence, and although I have striven for an understanding of the 'whole', I have used physical and mental pain as linguistic categories. I do however acknowledge that the translation of embodied experiences into a verbal presentation is in many ways a reduction of lived life.

REFERENCES

Aldwin, C.M. (2007). *Stress, coping, and development: An integrative perspective.* The Guilford Press.

Antonovsky, A. (1979). *Health, stress, and coping*. Jossey-Bass Publishers.

Axelsen, E.D., & Wessel, E. (2006). Den traumatiserte hukommelse. Hvordan fungerer hukommelsen ved senvirkninger etter traumer? In T. Anstorp, K. Benum & M. Jakbsen (Eds.), *Dissosiasjon og relasjonstraumer. Integrering av det splittede jeg* (pp. 60-72). Universitetsforlaget.

Baltazar, M. & Saarikallio, S. (2017). Strategies and mechanisms in musical affect self-regulation: A new model. *Musicae Scientiae, 23*(2), 177–195. doi: 10.1177/1029864917715061

Bernatzky, G., Presch, M., Anderson, M., & Panksepp, J. (2011). Emotional foundations of music as a non-pharmacological pain management tool in modern medicine. *Neuroscience and Biobehavioral Reviews*, *35*(9), 1989-1999. doi: 10.1016/j.neubiorev.2011.06.005

Berrahal, I., Ayadi, B., & Haddad, M. (2017). Depression Among Chronic Pain Patients. *European Psychiatry*, *41*(S1), S708-S708. doi: 10.1016/j.eurpsy.2017.01.1262

Binder, P.E., Nielsen, G.H., Vøllestad, J., Holgersen, H., & Schanche, E. (2006). Hva er relasjonell psykoanalyse? Nye psykoanalytiske perspektiver på samhandling, det ubevisste og selvet. *Tidsskrift for norsk psykologiforening, 43*(9), 899-908.

Blaxter, M. (2004). *Health.* Polity Press.

Burkitt, I. (2008). *Social selves: Theories of self and society* (2nd ed.). Sage.

DeNora, T. (2000). *Music in everyday life.* Cambridge University Press.

Engel, G.L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*(4286), 129-136. doi: 10.1126/science.847460

Ferreira-Valente, M. A., Pais-Ribeiro, J. L., & Jensen, M. P. (2014). Associations between psychosocial factors and pain intensity, physical functioning, and psychological functioning in patients with chronic pain: A cross-cultural comparison. *The Clinical Journal of Pain*, *30*(8), 713–723. doi: 10.1097/AJP.0000000000000027

Flick, U. (2006). *An introduction to qualitative research* (3rd ed.). Sage.

Gold, A., & Clare, A. (2012). An exploration of music listening in chronic pain. *Psychology of Music, 41*(5), 545-564. doi: 10.1177/0305735612440613

Grewal, D.D., & Salovey, P. (2006). Benefits of emotional intelligence. In M. Csikszentmihalyi & I. S. Csikszentmihalyi (Eds.), *A life worth living: Contributions to positive psychology* (pp. 104-119). Oxford University Press.

Hsieh, C., Kong, J., Kirsch, I., Edwards, R.R., Jensen, K.B., Kaptchuk, T.K., & Gollub, R.L. (2014). Well-loved music robustly relieves pain: A randomized, controlled trial. *PLOS One, 9*(9): e107390. doi: 10.1371/journal.pone.0107390.

Kirkengen, A.L. (2017). Creating chronicity. *Journal of Evaluation in Clinical Practice, 23*(5), 1071-1074. doi: 10.1111/jep.12715

Kirkengen, A.L. (2018). From wholes to fragments to wholes – what gets lost in translation? *Journal of Evaluation in Clinical Practice, 24*(5), 1145-1149. doi: 10.1111/jep.12957

Kirkengen, A.L., & Næss, A.B. (2015). *Hvordan krenkede barn blir syke voksne* (3rd ed.). Universitetsforlaget.

Kvale, S., & Brinkmann, S. (2014). *InterViews: Learning the craft of qualitative research interviewing* (3rd ed.). Sage.

Larsen, R.J., & Prizmic, Z. (2004). Regulation of emotional well-being: Overcoming the hedonic treadmill. In M. Eid & R. J. Larsen (Eds.), *The science of subjective well-being* (pp. 258-289). The Guilford Press.

Lee, J. H. (2016). The effects of music on pain: A meta-analysis. *Journal of Music Therapy*, *53*(4), 430-477. doi: 10.1093/jmt/thw012

Linnemann, A., Kappert, M.B., Fischer, S., Doerr, J.M., Strahler, J., & Nater, U.M. (2015). The effects of music listening on pain and stress in the daily life of patients with fibromyalgia syndrome. *Frontiers in Human Neuroscience, 9*, Article 434. doi: 10.3389/fnhum.2015.00434

McFerran, K.S. (2016). Contextualising the relationship between music, emotions and the well-being of young people: A critical interpretive synthesis. *Musicae Scientiae*, *20*(1), 103-121. doi:10.1177/1029864915626968

Meints, S. M., & Edwards, R. R. (2018). Evaluating psychosocial contributions to chronic pain outcomes. *Progress in Neuro-Psychopharmacology & Biological Psychiatry*, *87*(Pt B), 168–182. https://doi.org/10.1016/j.pnpbp.2018.01.017

Merleau-Ponty, M. (2002). *Phenomenology of perception.* Routledge Classics.

Mitchell, L., & MacDonald, R. (2006). An experimental investigation of the effects of preferred and relaxing music listening on pain perception. *Journal of Music Therapy, XLII*(4), 295-316. doi: 10.1093/jmt/43.4.295

Mitchell, L., & MacDonald, R. (2012). Music and pain: Evidence from experimental perspectives. In R. MacDonald, K. Gunter & L. Mitchell (Eds.), *Music, health, and wellbeing* (pp. 230-238). Oxford University Press.

Mitchell, L.A., MacDonald, R.A.R., Knussen, C., & Serpell, M.G. (2007). A survey investigation of the effects of music listening on chronic pain. *Psychology of Music, 35*(1), 37-57. doi:10.1177/0305735607068887
Mæland, J.G. (2016). *Forebgyggende helsearbeid. Folkehelsearbeid i teori og praksis* (4th ed.). Universitetsforlaget.
Pothoulaki, M., MacDonald, R., & Flowers, P. (2012). The use of music in chronic illness: Evidence and arguments. In R. MacDonald, K. Gunter & L. Mitchell (Eds.), *Music, health, and wellbeing* (pp. 239-256). Oxford University Press.
Ruud, E. (2007). Kropp og gester i musikalske samhandlinger. *Psyke & Logos, 28*(1), 122-137.
Ruud, E. (2013a). *Musikk og identitet* (2nd ed.). Universitetsforlaget.
Ruud, E. (2013b). Can music serve as a “cultural immunogen”? An explorative study. Special Issue on Music, Health and Wellbeing. *International Journal of Qualitative Studies on Health and Wellbeing*, *8*. https://doi.org/10.3402/qhw.v8i0.20597
Ruud, E. (2017). Music, identity, and health. In MacDonald, R., Hargreaves, D.J., & Miell, D. (Eds.), *Handbook of musical identities.* Oxford University Press.
Saariaho, A.S., Saariaho, T.H., Mattila, A.K., Karukivi, M.R., & Joukamaa, M. (2013). Alexithymia and depression in a chronic pain patient sample. *General Hospital Psychiatry*, *35*(3), 239-245. doi: 10.1016/j.genhosppsych.2012.11.011
Saarikallio, S. (2011). Music as emotional self-regulation throughout adulthood. *Psychology of Music*, *39*(3), 307-327. doi:10.1177/0305735610374894
Saarikallio, S., Baltazar, M. & Västfjäll, D. (2017). Adolescents’ musical relaxation: Understanding related affective processing. *Nordic Journal of Music Therapy, 26*(4), 376-389. doi: 10.1080/08098131.2016.1276097
Saarikallio, S., Gold, C. & McFerran, K. (2015). Development and validation of the Healthy-Unhealthy Music Scale. *Child and Adolescent Mental Health, 20*(4), 210-217. doi: 10.1111/camh.12109
Schäfer, T., Sedlmeier, P., Städtler, C. & Huron, D. (2013). The psychological functions of music listening. *Frontiers in Psychology, 4*, Article 511. doi: 10.3389/fpsyg.2013.00511
Schleimacher, F. (1998). *Hermeneutics and Criticism and other Writings* (A. Bowie, Trans.). Cambridge University Press.
Skånland, M. S. (2011). Use of mp3-players as a coping resource. *Music and Arts in Action*, *3*(2), 15-33. http://www.musicandartsinaction.net/index.php/maia/article/view/mp3copingresource
Skånland, M. S. (2012). *A technology of well-being: A qualitative study on the use of MP3 players as a medium for musical self-care*. Lambert Academic Publishing.
Skånland, M. S. (2013a). A young woman’s narrative on the role of mobile music in coping with everyday life. In L. O. Bonde, E. Ruud, M. S. Skånland & G. Trondalen (Eds.), *Musical life stories: Narratives on health musicking* (pp. 59-74). Centre for Music and Health Publication Series, vol. 6. Oslo: NMH-Publikasjoner 2013:5.
Skånland M. S. (2013b). Everyday music listening and affect regulation: The role of MP3 players. *International journal of qualitative studies on health and well-being, 8,* 20595. doi: 10.3402/qhw.v8i0.20595
Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research.* Sage.
Thayer, R., Newman, J.R., & McClain, T.M. (1994). Self-regulation of mood: Strategies for changing a bad mood, raising energy, and reducing tension. *Journal of Personality and Social Psychology, 67*(5), 910-925. doi: 10.1037//0022-3514.67.5.910
Thoma, M.V., Ryf, S., Mohiyeddini, C., Ehlert, U., & Nater, U.M. (2012). Emotion regulation through listening to music in everyday situations. *Cognition and Emotion*, *26*(3), 550-560. doi: 10.1080/02699931.2011.595390
Thoma, M.V., Scholz, U., Ehlert, U., & Nater, U.M. (2012). Listening to music and physiological and psychological functioning: The mediating role of emotion regulation and stress reactivity, *Psychology & Health*, *27*(2), 227-241. doi: 10.1080/08870446.2011.575225
Trondalen, G. (2016). *Relational music therapy: An intersubjective perspective.* Barcelona Publishers.
Vaajoki, A., Pietilä, A.-M., Kankkunen, P., & Vehviläinen-Julkunen, K. (2011), Effects of listening to music on pain intensity and pain distress after surgery: An intervention. *Journal of Clinical Nursing, 21*(5-6), 708-717. doi: 10.1111/j.1365-2702.2011.03829.x.
Van Goethem, A. (2010). *Affect regulation in everyday life: Strategies, tactics, and the role of music.* Doctoral Dissertation. Keele University.
Van Goethem, A., & Sloboda, J. (2011). The functions of music for affect regulation. *Musicae Scientiae*, *15*(2), 208-228. doi:10.1177/1029864911401174
Van Houdenhove, B., Luyten, P., & Egle, U.T. (2009). The role of childhood trauma in chronic pain and fatigue. In V.L. Banyard, V.J. Edwards, & K. Kendall-Tackett (Eds.), *Trauma and physical health: Understanding the effects of extreme stress and of psychological harm* (pp. 37-64). Routledge.
Vist, T., & Bonde, L.O. (2013). “Then certain songs came”: Music listening in the grieving process after losing a child. In L. O. Bonde, E. Ruud, M. S. Skånland & G. Trondalen (Eds.), *Musical life stories: Narratives on health musicking* (pp. 139-164). Centre for Music and Health Publication Series, vol. 6. Oslo: NMH-Publikasjoner 2013:5.

Ελληνική περίληψη | Greek abstract

«Η μουσική είναι κάτι για να κρατηθώ: μια σανίδα σωτηρίας» – Η μουσική ακρόαση στη διαχείριση της ζωής με χρόνιο πόνο και άγχος

Marie Strand Skånland

ΠΕΡΙΛΗΨΗ

Αυτό το άρθρο παρουσιάζει μια μελέτη περίπτωσης που διερευνά το ρόλο της μουσικής ακρόασης στη διαχείριση της ζωής με χρόνιο πόνο και άγχος. Η ενασχόληση με τη μουσική μπορεί να μειώσει την υποκειμενική εμπειρία του πόνου και μπορεί να είναι ένα πολύτιμο εργαλείο αυτορρύθμισης και συναισθηματικής διαχείρισης. Εντούτοις, η ενασχόληση με τη μουσική και οι επιδράσεις που προκύπτουν από αυτήν είναι σε μεγάλο βαθμό εξατομικευμένες και πολύπλευρες και ως εκ τούτου είναι δύσκολο να γίνουν γενικεύσεις αναφορικά με το ρόλο της μουσικής σε σχέση με τη φυσιολογική και ψυχολογική λειτουργία. Αντ' αυτού, η παρούσα περίπτωση συνιστά μια ιδιογραφική ερευνητική προσέγγιση, βασισμένη στην αντίληψη ότι η σε βάθος ποιοτική έρευνα ατομικών προσωπικών εμπειριών ίσως μπορεί να διευρύνει τη βάση των γνώσεών μας. Με τη χρήση της ερμηνευτικής φαινομενολογικής ανάλυσης, αυτό το άρθρο παρουσιάζει μια πλούσια, ατομική περίπτωση μιας γυναίκας που έπασχε από χρόνιο πόνο ο οποίος σχετιζόταν με τραύματα κατά την παιδική ηλικία. Μια συνέντευξη σε βάθος διερεύνησε τις καθημερινές συνήθειες της συνεντευξιαζόμενης αναφορικά με τη μουσική ακρόαση και το πώς αυτές σχετίζονταν με τις δικές της εμπειρίες σωματικού και ψυχικού πόνου. Η συνεντευξιαζόμενη ακούει μουσική για να αμβλύνει την εμπειρία του σωματικού πόνου, για να αποσπάσει την προσοχή της από την ψυχολογική δυσφορία, για να κρατηθεί στο εδώ και τώρα και για να παρουσιάσει τον υγιή της εαυτό. Αυτή η περίπτωση μπορεί να ενισχύσει τον τρόπο με τον οποίο κατανοούμε τη μουσική ακρόαση ως μια δεξιότητα ολιστικής διαχείρισης της ζωής για την αντιμετώπιση του χρόνιου πόνου και του τραύματος, και τονίζει την αλληλοσύνδεση σώματος, συναισθήματος και νόησης.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

μουσική ακρόαση, χρόνιος πόνος, ημικρανίες, τραύμα, διαχείριση πόνου, συναισθηματική ρύθμιση, ταυτότητα, διαχείριση ζωής, μελέτη περίπτωσης, φαινομενολογία

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APPROACHES

ARTICLE

'It's just a different dimension': Music therapists' experiences of hearing loss

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ABSTRACT

This study explores the lived experiences of qualified music therapists who identify as having hearing loss. The risk of hearing loss for professional musicians is widely acknowledged in literature, with one study demonstrating an increased risk of hearing loss for music therapists. No current literature, however, explores the experiences of hearing loss from the perspective of the music therapist, in a profession in which hearing and listening could be seen as central to the work. For this study, qualitative research methods were employed, involving semi-structured interviews with six music therapists experiencing different levels of hearing loss. Verbatim transcripts were then analysed, using interpretative phenomenological analysis (IPA), resulting in the identification of three principal themes across the data set: 1) Listening is exhausting: Identity as a music therapist with hearing loss; 2) Impatient or intrigued? Stigma versus support; and 3) How I manage: Strategies for coping. These themes are discussed in-depth, in light of existing theory and implications for practice. The analysis supports existing research demonstrating that acquired hearing loss does not impede musical ability. Barriers to proficiency arise from other areas. Implications are discussed, including recommendations for hearing-protection training within music therapy training programmes.

KEYWORDS

hearing loss,
music therapy,
identity,
stigma,
hearing protection,
musicians' health

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INTRODUCTION

The aim of this study is to open up a currently under-researched topic and give music therapists an opportunity to explore the impact of hearing loss in a profession in which listening and hearing could

be considered fundamental within the clinical context. This project is not focused on deafness per se, the Deaf community or deaf identity. Rather, the aim is to explore the perspectives of music therapists who identify as having hearing loss (which may include profound deafness) and their personal experiences of this, as therapists. It is hoped the study will provide a greater understanding of the potential impact of hearing loss and explore the need for more research in this area.

The paper begins with a literature review, moving from a brief summary of where the main focus of research around hearing loss lies, through to the growing recognition of the prevalence of hearing loss in musicians and, more recently, an acknowledgment of the risk of hearing loss for music therapists. The design, methodology and data analysis of the study are detailed, followed by a results section in which verbatim extracts are presented and analysed through three identified principal themes. The final discussion introduces some new relevant literature and includes the limitations of the study, leading to the conclusion and final recommendations.

LITERATURE REVIEW

According to the World Health Organisation, approximately one third of people over 65 become affected by disabling hearing loss (WHO, 2020). Unsurprisingly, therefore, most studies exploring the physiological aspects and personal experiences of hearing loss are focused on acquired hearing loss in older adults, due to the prevalence of this particular sensory impairment in the older population (Baldridge & Kulkarni, 2017; Simmons, 2005). People with hearing loss may be considered hard of hearing, deaf or Deaf. The capital D denotes personal identification with the Deaf community and with Deaf culture. Members of the Deaf community are often born deaf and, largely due to the use of sign language, consider their deafness to be an intrinsic part of their identity and culture, rather than something that needs to be treated, managed or adjusted to (Darrow, 2006; Ladd, 2003). The majority of people with hearing loss, however, acquire it during their lifetime, having to adjust to the change and loss over time (Dalebout, 2009; Simmons, 2005).

Significantly, a growing number of studies are showing an increase in the prevalence of acquired hearing loss in people of all ages, due in part to a recognition of the alarming increase in noise-induced hearing loss (Jennings et al., 2013). Many studies explore the psychosocial experiences of hearing loss, including the effects on communication, a lack of appropriate hearing aids or assistive technologies and the widely acknowledged stigma of hearing loss (Lysons, 1996; Wallhagen, 2009). Significantly, research has shown that many people feel unable to face or address problems in hearing, which has led to what has been described as an 'epidemic' of untreated hearing loss (Foss, 2014).

Hearing loss in musicians

For musicians, whose livelihood may depend on their ability to hear, the impact of hearing loss may be multiplied. Many studies have shown an increased risk of hearing loss for musicians (Chasin, 2009) and for people working in the music industry, due to the level of noise exposure and the intensity of the music they experience (Berg et al., 2016; Di Stadio, 2017; Jenson et al., 2009). One study concluded that professional musicians could be almost four times more likely to develop hearing loss than the general public (Schink et al., 2014). Music-induced hearing loss appears to be

becoming a widespread and yet little acknowledged or accepted phenomenon (Khatter, 2011).

Some studies emphasise that music-induced hearing loss is also prevalent within the context of music education and music tuition (Beach & Gilliver, 2015; Chesky, 2008; Hayes, 2013). The findings in Beach and Gulliver's study (2015) which looked at noise exposure for instrumental music teachers showed that despite many teachers considering themselves to be at low risk from their music-related noise exposure, audiograms showed hearing loss in nearly half the participants. Significantly, many of the music teachers in the study downplayed the risk of noise damage from their musical activities. This could indicate a lack of awareness of the risk but may also be due to internal conflict manifesting in the denial of the risk in the presence of knowledge. Indeed, the invisibility of hearing loss makes it less likely to be acknowledged openly or accepted internally, leading to a strong possibility of denial (Sebastian et al., 2015). Reasons for little recognition or acknowledgment of hearing damage within these contexts could be linked with lingering stigma around deafness and hearing loss but could also reflect a lack of understanding of its potential severity (Dalebout, 2009; Wallhagen, 2009).

As clearly demonstrated by the profoundly deaf percussionist Evelyn Glennie, among many other deaf musicians, hearing loss is not in itself a barrier to music-making or attaining a highly professional level of musicianship (Darrow, 2006). Indeed, a successful and growing UK charity, Music and the Deaf, founded by a profoundly deaf pianist, shows, unequivocally, that hearing loss itself need not be a barrier to making and enjoying music (Music and the Deaf, 2020). Furthermore, an observational study on the effects of hearing impairments on verbal and non-verbal communication during collaborative musical performance showed little evidence of hearing loss affecting social interaction (Fulford & Ginsborg, 2014). However, in order for deaf musicians (or musicians with any level of hearing loss) to perform and interact musically, there are factors which may present challenges, for example with regard to the differing ways in which people process and understand sounds (Bathurst, 2017). Significantly, for people wearing hearing aids or who have cochlear implants, there is the potential deficit in the discernment of pitch and sound quality, which may affect connection and enjoyment (Beck, 2014). Visual communication is of paramount importance, so the position of people in the performance space needs to be carefully considered (Fulford & Ginsborg, 2014). Potential psychological effects of hearing loss should also be acknowledged, such as loss of confidence or feelings of isolation, which may in turn affect levels and quality of musical connection (Manchaiah & Danermark, 2016; Simmons, 2005).

Music therapists and hearing loss

What, then, of musicians with hearing loss working in a therapeutic context, in situations where interactions are less likely to be controlled and may be hard to predict? In order to respond appropriately to a client's needs, a music therapist needs to be finely attuned to all forms of expression from the client, including the tiniest movement or sound (Bunt & Stige, 2014; Wigram, 2004). As such, listening, hearing and responding could be said to be central to a music therapist's work. The importance of the communicative role of music in this context cannot be overstated (Malloch & Trevarthen, 2009). What impact, then, might hearing loss have on a music therapist's work and identity?

There is a growing body of literature about deaf musicians (Darrow, 2006) with some studies exploring music therapy work with people with hearing loss (Gfeller, 2007; Robbins & Robbins, 1980; Ward, 2016), and the different ways that people may learn to hear, feel and play music (Abrams, 2011; Bang, 2009; Salmon, 2009). There is a dearth in studies, however, looking specifically at hearing loss in music therapists and their experiences, or the potential for clinical work itself to damage hearing. One study measured the level of noise experienced by a music therapist over the course of two weeks (MacMahon & Page, 2015) and highlighted the risk of hearing loss for people working as music therapists, due to the regular exposure to loud noise at close range. The improvisational nature of much music therapy (Wigram, 2004) adds another risk factor for music therapists, as impulsive sound has been shown to be more damaging to hearing than continuous noise (Clifford & Rogers, 2017; Starck et al., 2003). The study by MacMahon and Page (2015) had limitations, including lack of comparable studies and the variables which made it impossible to say for certain what level of occupational noise that music therapists would be exposed to (and the possible subsequent hearing damage which may occur). However, the findings were important and informative, raising awareness for the first time of the potential for music therapy work to damage hearing.

No current studies, however, look at the experiences of hearing loss from the perspective of the music therapist. This could be due to the relatively small demographic of music therapists, and even smaller demographic with hearing loss. Other reasons for the lack of research in this area could include awareness of the stigma associated with hearing loss and fear of judgment or criticism with regard to professional ability (Foss, 2014; Wallhagen, 2009). Lack of awareness of the potential for music therapy work itself to damage hearing could also be a contributing factor to the gap of literature or research in this area.

METHOD

Design and methodology

The qualitative methodology chosen in order to undertake the research was interpretative phenomenological analysis (IPA) (Eatough & Smith, 2006; Freeman, 2008; Hefferon & Gil-Rodriguez, 2011; Reid et al., 2005; Smith & Osborn, 2003; Smith et al., 2009). The diverse nature and manifestations of hearing loss, combined with personal and complex music therapy approaches, meant each participant's narrative would be rich and unique, thus worthy of the in-depth scrutiny that is at the core of IPA.

Prior to recruitment for the research, ethical approval was received from the Health and Applied Sciences Faculty Research Ethics Committee at the University of the West of England (reference number: RG310118SC). Purposive sampling was used for recruitment, identifying participants based upon predetermined selection criteria (Braun & Clarke, 2013; Silverman, 2014; Yardley, 2000). As such, participants were required to be music therapists who identified as having hearing loss. The aim was to recruit a relatively homogenous sample, as is typical of IPA studies (Smith et al., 2009; Smith & Osborn, 2003).

The number of years since qualifying ranged from 4 years to over 30 years. Levels of hearing loss ranged from mild high-frequency hearing loss to severe deafness (Table 1). To ensure

anonymity of the participants and due to the potential sensitivity of the subject for some, no further details of participants are given.

Pseudonym	Level and onset of hearing loss
Andy	Bilateral deafness from birth (severe)
Bella	Bilateral deafness from birth (severe)
Christine	Acquired high-frequency hearing loss in adulthood (mild, undiagnosed)
Daisy	Acquired high-frequency hearing loss in adulthood (moderate)
Edward	Unilateral deafness from early age (profound in one ear)
Florence	Unilateral deafness from early age (profound in one ear)

Table 1: Level and onset of participants' hearing loss

All hearing loss was self-reported during the interviews rather than verified using audiometric data. Data were collected using semi-structured interviews. Three of the six participants wore hearing aids. All participants were able to communicate in spoken English, so no adjustments were required in order to make participation accessible. The interviews were between 50 and 90 minutes in duration. Four interviews took place face-to-face; two took place over Skype. The flexibility of the interview allowed participants to explore their experiences without constraint. As music therapists, not audiologists, neurologists or acousticians, we make no pretence to be experts in the fields of hearing loss or hearing preservation. One of us is a music therapist with severe tinnitus and possible mild hearing loss, which gives an elevated level of researcher subjectivity. The advantages and limitations of this position are acknowledged in a subsection in the discussion.

Data analysis

The audio data was transcribed verbatim to prepare for analysis. To ensure anonymity, all participants have been given pseudonyms and, aside from levels and onset of hearing loss, all identifying details have been removed. To begin analysis, each interview was read, and then twice reread, in order to feel fully immersed in the narrative (Smith et al., 2009). Initial exploratory comments were then made on the right-hand side of the transcript, pointing to any notable linguistic, conceptual or descriptive elements. Following this, emergent themes that linked significant features of the data were noted on the left-hand side of the transcript. Any significant, relevant quotes were highlighted. Developing from these initial steps, connections were then made between the emergent themes. This was achieved by making a visual representation of the data and drawing out interrelationships within the themes, in order to refine the focus of the analysis. This process resulted in the identification of a small number of higher-level superordinate themes. These steps were then repeated for each subsequent case.

Following close scrutiny of the superordinate themes across the cases and the connections between them, three principal themes were identified:

Theme one: Listening is exhausting: Identity as a music therapist with hearing loss
Theme 2: Impatient or intrigued? Stigma versus support
Theme 3: How I manage: Strategies for coping

The three themes were scrutinised, with verbatim extracts from each participant, to form the final analysis and ensuing discussion. An additional process of gathering participant feedback from all six participants was carried out in order to validate the authenticity of the data. This involved asking participants to read through the study and note any sections which they felt needed clarification or modification. It was particularly important that the participants agreed to the chosen verbatim extracts presented in the results section. Three of the six participants sent revised transcripts, indicating where they felt the extracts or sections of the manuscript needed clarification.

RESULTS

The three themes are now presented with the chosen verbatim extracts and analysis. On occasion the results are presented alongside relevant in-text citations pointing the reader to relevant literature.

Theme one: Listening is exhausting: Identity as a music therapist with hearing loss

The fear of missing something significant within the clinical setting was a recurring concern for participants, and exacerbated by the intensity of a therapeutic relationship and the importance of the communication within it. Two participants acknowledged the anxiety they experienced when their hearing loss caused them to miss something within the clinical context:

> The stress levels go up when you're watching lip patterns carefully and you can't understand it and then they say it again and you still don't know. It's exhausting and demoralising. (Bella)

> It's certainly changed how I work, and I'm definitely conscious of it at all times [...] A few weeks ago I was in a group and somebody mumbled something, it was something significant and I wasn't getting it... I asked three times and I couldn't get it [...] I felt awful. (Daisy)

Both comments accentuate the barrier that hearing loss can create and the resulting rising anxieties that can be experienced when important things are felt to be missed. Daisy's response is a stark example of a negative impact of hearing loss, in which internal feelings of guilt arise (Arnason, 2003).

Another notable recurring feeling expressed by the participants was insecurity around professionalism, due in part to the difficulty in discerning sound in groups and sensitivity to peripheral noise. In addition to problems posed in clinical sessions, it was clear that meetings posed

significant problems for participants, as seen in the following extracts:

> Meetings at work when I was missing things... people start talking quickly between the two of them and they're not talking to the whole group, and everyone else is picking it up, except for me. (Daisy)

> My team was at the other end of this big office and the other team were all talking to each other and it just made it impossible. These sorts of things I am really sensitive to and I found myself really craning to hear what was happening. I felt exhausted afterwards. (Christine)

The tiring aspect of listening is prominent within the narratives; something which perhaps may not be appreciated by those who have not experienced hearing loss. Bella expresses this powerfully in the following comment, giving us an insight into both the intensity of trying to listen with a hearing loss and the frustrations that can then extend to others who may not understand:

> My ability to actually listen is very acute so I am absolutely focused and it annoys me when I'm in a meeting and people have missed something because they've only listened with half an ear. You're working really hard to keep up but the hearing can afford not to care when they get it wrong. (Bella)

The implication here is that the styles of auditory attending can vary considerably. Bella's comment suggests those who do not have a hearing loss can sometimes be more complacent in their listening. This could instigate feelings of resentment and highlights again the invisibility of hearing loss and the silent, inner struggles that may be little acknowledged by others (Simmons, 2005; Herbst, 2000).

Whilst all participants did point to the difficulties experienced in group scenarios, the levels of frustration did vary significantly, from deep distress to mild irritation. Indeed, one participant was often humorous in his narrative, which could be seen as a coping mechanism, but could also just be a reflection of his self-efficacy:

> It's just a bit of a hassle sometimes. I sometimes think I'd like to have like an old Victorian ear trumpet that goes under my chin, I could just hold it there, an old brass ear trumpet – it would be quite funny! (Edward)

Another participant was also openly honest and humorous about her deafness, but she did acknowledge some anxieties, including concern that she may be unintentionally seeming to ignore others:

> I have honestly considered having 'I am deaf' tattooed on me at some point because, yeah, I always worry that I'm ignoring people. (Florence)

Significantly, one participant talked openly about reaching a point of such distress that he considered leaving the music therapy profession:

> I just wish sometimes people would give me a chance, you know? [...] At one point I really felt like giving it all up, you know – sod this, I'll do something else! But then I said to myself, 'Well, I'll hang on in there.' (Andy)

This could be seen as a powerful illustration of the internal struggle that has been ongoing for Andy. His strong desire to continue his work as a music therapist is evident, despite relentless barriers and never feeling truly accepted or respected in the field. His resolve to 'hang on in there' is testament to his inner determination during what has clearly been (and continues to be) a complex and difficult journey.

For Bella, struggles have stemmed less from the response from others and more from the intensity of the work and the effort of listening:

> It's very tiring. It really is wearing, mentally, because the processing is constant. Conscious listening is exhausting and being a music therapist is exhausting, even though it is an amazing profession to be in [...] and at the end of the day, you know, you've certainly had enough. (Bella)

For Daisy, her acquired hearing loss has been a challenge in the sense that there has been quite a dramatic shift in the way she has felt able to work:

> It's knocked my confidence to do work. I mean, I've got a lot more inner confidence that I can be with someone and know that it's useful... but then again, I don't know. (Daisy)

Daisy's statement suggests that she is also battling with an internal struggle. Whilst she knows she is a capable and professional music therapist with confidence in her own abilities, she is also acutely aware of the significant change and the enormity of adjustment. She has had to deal not only mentally and emotionally with the loss of hearing but also adjust physically to her hearing aids and the resulting different presentation of sound. Crucially, as well as requiring a physical adjustment, adapting to hearing aids is also a long, complex, ongoing psychological process.

In addition to expressing the struggles, some participants were also keen to emphasise the communicative strength of music and the potential for music therapists to connect with others on a different level, through music, without the need for words:

> It's a real privilege actually, to be able to work as music therapists, I think, and it really helps you to appreciate the power of music and how it can sort of act as a different vehicle... without words... and can transcend things as well. (Christine)

Furthermore, there was acknowledgement of the shared sense of humanity between therapist and client due to the shared experience of living with hearing loss, as is poignantly expressed by Bella in the following extract:

> People say, 'Gosh, how is it that you're doing what you're doing and you're deaf?' Well, actually it makes sense, doesn't it, because you know what it's like to be isolated, you know what it is to be anxious and different, and you know what music means to you, so you understand the power of actual connection at an intrinsic level. (Bella)

Theme two: Impatient or intrigued? Stigma versus support

All six participants seemed to have strong feelings about how others perceived them; whether they felt stigmatised due to their hearing loss in such a music-based profession, or, conversely, if the response was a positive, supportive or even intrigued one.

One participant pointed to the stigma he believed was attached to his deafness and the resulting mistrust he felt from the music therapy community:

> So I did a music therapy conference… it was strange because people were a little unsure, you know? They don't know how to deal with you, afraid of talking to you sometimes, because of my deafness [...] Even some of the music therapists were so traditional, straitjacket, they didn't like the idea that there was a disabled person qualified in music therapy. There was a stigma attached to it. (Andy)

Despite being a qualified music therapist, Andy has continued to feel judged and misunderstood within the profession. His shift from past tense to present tense and back to the past tense again could be a reflection of his ongoing struggle over time. Noting his own deafness amidst his general statements about fear and stigma could also highlight the isolation he has felt.

Daisy's anger and frustration are apparent, too, in her personal observations which reflect the widespread negativity around hearing loss:

> You know, people get annoyed, because it's invisible, and people don't make the adjustments. People just think they [people with hearing loss] are stupid and they get impatient. (Daisy)

During the interview she also talked on a more personal level about her own feelings as a music therapist with hearing loss. These included fear of increased hearing loss over time and the frustration she has felt at not being taken seriously in the work place with regard to her hearing loss:

> In fact, hearing aids is the only thing that has made managers engage with me in relation to concerns about hearing loss. Nobody has taken me seriously before. (Daisy)

For Daisy, the move to wearing hearing aids, thus making the impairment a visible one, was a significant move towards her hearing loss being more recognised and thus more understood by others, with employers taking her need for support more seriously.

For Andy, despite seemingly never feeling fully embraced by the profession, there was a notable shift towards a more accepting place:

> I felt totally rejected by the music therapy community, and I still do! Although I think that's changed now since we went to the conference this year... people were much more open, more aware, I think. So I think there's been a change, somehow, in attitude. (Andy)

This development is less linked with any practical changes he has made but appears to be more a result of a gradual shift in attitude and levels of acceptance of disability and hearing loss in the music therapy community. Significantly, despite this shift, to talk of feeling 'totally rejected' by the music therapy community would suggest that his struggle to be accepted is pervasive and ongoing.

Another participant, Bella, also expressed how she had felt misunderstood by some. In contrast to Andy, however, lack of understanding was more often from outside of the music therapy field, for example from some audiologists who did not appreciate the difference in listening required by musicians. That hearing aids are designed primarily to optimise the intelligibility of speech is a well-researched area (Hearing Aids for Music, 2020) and highlights the problems faced by musicians needing appropriate and satisfactory hearing aids. The complex listening required as an interactive musician, further intensified by being deaf, Bella explained, is rarely understood by audiologists. The following extract highlights her frustration:

> A surprising proportion [audiologists] are only interested in speech and it's insulting. I will explain how my job is, as an interactive musician and they'll just say, 'Well, tough!' and that a standard music programme on the aid will be fine for 'listening to Classic FM!' (Bella)

Whilst she noted that real understanding of her hearing loss was limited, Bella did acknowledge that, in contrast to Andy's experience, people within the music therapy profession were generally positive:

> I think people are sort of astonished but just don't understand it, really. People who are in the field are generally quite respectful; they understand something about it, however limited, and that's fine. (Bella)

This view is echoed by Florence, who also experienced positive reactions from others:

> The main response I get, when I tell people I've got a hearing impairment, is they're like, 'Wow! That's amazing you're a music therapist,' and I feel a bit bashful because I think it doesn't feel relevant. (Florence)

That people are 'astonished' or consider it 'amazing' to be a music therapist with hearing loss is perhaps a reflection of lingering common assumptions around deafness and musical ability.

Florence clearly does not feel that her hearing loss should hold any significance with regard to her ability as a music therapist. Interestingly, her later comment reflects her view that not having to adjust to a hearing loss was also a contributing positive factor:

> It would be totally different if I'd acquired the hearing loss after learning music, you know? (Florence)

This could be seen as implying that those with acquired hearing loss may struggle more with regard to musical development and ability than those who have not known any different, but could also purely be an acknowledgement of the complexities inherent in adjusting to hearing loss.

Surprisingly, one participant, who also talked about experiencing positive reactions from others, suggests that stigma could be seen as something self-created and that it is one's personal responsibility to present something positively in order that it may be positively received:

> In my experience, it's how you present something kind of dictates whether it becomes a stigma with other people […] If anything, people are more intrigued… (Edward)

This strong view reflects Edward's robust attitude and his personal confidence in his abilities as a music therapist with hearing loss. The suggestion that the existence of stigma is dependent on how individuals present themselves is interesting. One reading could be that this is a reflection of some level of internalised ableism, whereby the stigmatised narrative surrounding deafness has in some way been absorbed. Alternatively, Edward may be presenting a conscious challenge to those who may choose to project their own attitudes about his experience on to him.

Another participant, Christine, suggested that musicians may in fact be particularly understanding about deafness and hearing loss, due to the growing awareness of the prevalence of acquired hearing loss amongst musicians:

> Because it's an occupational hazard for musicians, I think that reduces the stigma, because we know there are musicians struggling with it […] I've never felt stigmatised. Maybe young people would be less patient? (Christine)

Whilst Christine does not feel personally stigmatised in any way, she recognises that hearing loss could instigate feelings of frustration in others, thus opening up the potential for stigma. This acknowledgement that hearing loss may incite impatience in others is echoed by Florence when she talks of having to ask people to say things again or to move positions (in meetings, for example) in order that she may be able to hear better:

> Sometimes it feels like people might get frustrated, if they're having to repeat stuff. […] I still worry that others may feel annoyed about the act of having to move seats, you know? (Florence)

Without giving any actual examples of impatient responses to her deafness, this could be seen as an example of internalised stigma, in which negative responses to deafness in society have been absorbed and applied to her own experience.

Theme three: How I manage: Strategies for coping

The need and desire to maintain professionalism and proficiency in the workplace was a prominent theme in the participants' narratives. The strategies employed by the music therapists, however, were strikingly diverse. Factors influencing their different approaches included: levels of hearing loss, use of hearing protection, choice of client group, means of musical communication and concerns for the future.

One participant was no longer able to work as a therapist within the clinical setting due both to the growing severity of his impairment and to additional significant personal physical needs. However, he talked positively about how he had been able to utilise and spread his music therapy knowledge and experience through a different medium:

> I've written some academic articles now, which have been a big help. That for me was my milestone for getting over this hurdle. (Andy)

Andy's use of the word 'hurdle' could be seen as an attempt to make the enormity of his struggle feel more manageable in his mind.

For two of the participants, strategies for coping with their hearing losses within clinical sessions were practical in the main. They considered their hearing impairments to be inherent to their beings and did not talk of any notable detrimental effects to their clinical work:

> You know, that's just how it is. It's just one of those things you adapt to so I don't consider it a disability [...] I always have my client on the right, just because of a much more subtle level of hearing I can get from that. (Edward)

> I have done more individual work than group work (..) I guess my deafness is kind of intrinsic to my experience of music and therefore doesn't affect my practice as a therapist, I guess? Hearing loss is just kind of there, as part of me. (Florence)

Bella, too, was clear about the work that she would avoid, noting that, because of her deafness and her need for intense focus, difficulties would arise from too much movement or too many words:

> I wouldn't want to put myself in a position where I was working with someone who really needed to use words. Because people don't keep their voice levels up, and if you're saying something emotional the chances are your voice drops. So I might miss the key word [...] and I would also not be able to work with someone who is verbal and running around the room; it wouldn't be fair on them or professional. (Bella)

Significantly, Bella was the only participant whose narrative focused almost exclusively on the significance of the musical interactions and need for finely tuning her musical skills as a strategy for working successfully.

> Music in deafness has to be stripped down, you have to really understand what you're working with, what your music is and how you're presenting your sound. When you work with special needs it's very different because then you use the whole spectrum of music [...] A major point is that you have to keep reinforcing your listening and checking that your personal knowledge of sound in music is accurate. (Bella)

This is a powerful demonstration of client-focused work and a deep knowledge of different ways that people may not only hear sound but also interpret and understand it (Ward, 2009; Sacks, 2007; Headlam, 2006; Levitin, 2006).

The focus on client need was paramount within the interviews, alongside an understanding of the importance of self-care as music therapists. Protection of remaining hearing was expressed by participants as an important element of self-care. One participant explained that she needed to seek protection for her hearing; a daunting prospect as she feared that it may knock her confidence:

> I don't want it to get worse [...] If I was going to be doing things with my hearing, it would probably make me feel a bit less confident again, just till I'd adjusted. (Christine)

Alongside the fear of hearing loss worsening and having to face the adjustment process, which would be psychological as well as physical, there was a recognition here of the importance of wellbeing as a therapist, including having the self-awareness to know if you are physically and emotionally capable of working at a professional level (Gro, 2016; Skovholt, 2012).

> That self-scrutiny you have to have as a music therapist, I think always has to be at that quite high level so that you are aware of...are you able to work or not? (Christine)

There were notable differences in the levels of openness that the participants showed towards clients about their hearing loss. Some did not see any relevance in telling clients, some actively hid their impairment during clinical sessions and others were more open:

> I'm a very open person, I'm not ashamed to talk about it and I think it's something that people need to understand. (Andy)

> I've never told a client. It's never felt necessary to do so. I have moulded earplugs so having them has made a big difference, and also you can slip them in kind of subtly, which is good, as I don't want clients to feel like they've done something wrong. (Florence)

> I don't think, 'Oh, this is my hearing problem,' I just think, 'I've got to optimise this environment for the patient and me.' (Christine)

All participants were notably and consistently sensitive to their clients' needs. Importantly, however, there is the danger that this sensitivity may override personal need and potentially lead to more hearing damage:

> I'm sort of always thinking, 'Well, is this too loud – should I be stopping it?' And almost always, it never feels like the most important thing, because you're with this person and finally got them to a place where they really need to be and the one thing you don't want to do is stop them. As a therapist you don't want to stop them. (Daisy)

Significantly, Daisy also acknowledges the importance of protecting not only her own hearing but that of her clients. Alongside her increasing personal anxiety about her hearing loss there has developed a growing assertiveness with regard to managing her own clinical space:

> I'm probably more assertive now about how to manage it than I used to be. I don't put the cymbal out [...] Thinking about how to protect your clients is no bad thing, and sometimes you need to stop being loud in order to start thinking. (Daisy)

This comment could be seen as an alternative and positive slant on something that might instinctively be seen in a negative way. Bringing awareness into the clinical setting of the need to protect hearing of both client and therapist could potentially result not just in minimising the risk of hearing damage but also in making space for therapeutic development. Furthermore, it could be said that the experience of hearing loss simply brings a new perspective into the clinical context:

> I am just bringing this thing that a lot of music therapists aren't; an added element in relation to the parameters and boundaries we work within. It's just a different dimension. (Daisy)

DISCUSSION

This study was an exploration into the experiences of six music therapists with hearing loss. There was substantial disparity between the levels, onset and types of hearing loss experienced by the participants and, of course, between their personal journeys as music therapists; this rich diversity was immediately present in their narratives. The three principal themes identified across the six cases explored issues connected with: personal challenges around extended listening, levels of awareness and understanding from others and, lastly, personal and social coping strategies. The analysis brought to the fore some of the participants' most significant experiences as music therapists with hearing loss, creating avenues for continued research in this area and, importantly, indicating areas of practice and training that may benefit from education and change.

Analysis of the narratives showed that hearing loss for these music therapists appeared to be experienced as one of the following within the workplace: an obstacle to be overcome, fully integrated, or irrelevant. It was not possible to clearly define these markedly different standpoints in relation to the level or onset of hearing loss experienced by the music therapists. Rather, their lived experiences were largely shaped by social and environmental factors and personal journeys as therapists, which, of course, were unique but also continuously changing and developing over time. Importantly, some common threads in the narratives did emerge.

The adjustment process required when wearing hearing aids or using hearing protection was highlighted, which is a widely researched and recognised area (Dalebout, 2009; Lane & Clark, 2016; Simmons, 2005). These complex adjustments are psychological as well as physical, and have been shown to affect levels of confidence and mental energy. Levels of musicianship of the therapist, however, were not affected. Indeed, there was nothing within the narratives that was indicative of a negative effect that hearing loss had on the music therapists' ability as musicians. This is consistent with a substantial body of research emphasising that hearing loss need not be a barrier to proficiency in musicianship (Darrow, 2006; Fulford & Ginsborg, 2014; Gfeller, 2007). The lack of detrimental effect to musical ability appeared consistent throughout the narratives, whatever the level and onset of hearing loss for the participants and whatever the client group they were working with. This could be a useful finding both for music therapy employers and for musicians with hearing loss who may be considering training as music therapists but who may see their deafness as a barrier to successful work in a music-based profession. It may also potentially counteract some common misconceptions around hearing loss and musical ability or musical connection (Darrow, 2006; Einhorn, 2012; Fulford at al., 2011).

The theory that all humans have an intrinsic predisposition to musicality from infancy (Stern, 1985; Trevarthen, 1997; Trevarthen & Malloch 2000) is now a widely recognised and accepted notion, underpinning much music therapy practice. The subsequent development of personal musical identities is then shaped by social and environmental factors (Hargreaves et al., 2002) but also by the different ways in which music is experienced and understood. For people with hearing loss, constructing and maintaining a musical identity may take a different path due to the different ways of listening, hearing and interpreting music. The need to 'hear' and try to understand what is being communicated, through whatever means, is fundamental to music therapy work. This emerged as a poignant element in the narratives. For the deaf music therapists working with deaf clients, for example, the emphasis was on visual communication, conscious listening, fine-tuning the presentation of sound and being acutely attuned to different ways that individuals process and understand sound and music (Darrow et al., 2000; Darrow & Novak, 2007). Interestingly, Levitin (2006), in his detailed exploration of the ways the brain perceives music, points to what he calls an 'astonishing' discovery that the regions of the brain that were active in following musical structure were the same ones that were activated when deaf people were communicating in sign language. This could be significant and positive when considering the strength of connection involving visual communication for deaf people in musical interaction.

Reflecting the mental effort required for listening, the participants' narratives supported existing literature which emphasises the widely experienced, yet little recognised, exhausting element of listening with a hearing loss (Morata et al., 2005; Nachtegaal et al., 2009). The potential

for cognitive fatigue due the mental exertion required for listening with a hearing loss should not be underestimated. For any therapist, an intense level of listening is required within the clinical context (King et al., 2012; Skovholt, 2012). For music therapists, this is elevated due to the multidimensional aspect of communication in a musical context, and the need to be finely tuned to every form of expression from the client. With a hearing loss, this intensity is exacerbated still. Literature on listening effort with a hearing loss points to the elevated exertion of cognitive resources needed in order to maintain a satisfactory level of listening (Desjardins, 2016; Rudner, 2016). Additionally, the 'capacity to filter and prioritise sound' is compromised (Bathurst, 2017), making it harder to discern sounds, with background noise being a significant barrier to focused listening.

An associated recurrent experience for the participants was the perception of impatience from other people, who, some felt, perhaps did not understand the mental effort required to listen. Impatience has long been acknowledged as a reaction to hearing loss, due in part to the invisibility of the impairment and to the stigma attached to hearing loss (Foss, 2014; Gooday & Sayer, 2017; Harold, 1985; Shohet & Bent, 1998; Simmons, 2005). Significantly, however, none of the participants experienced impatience or judgement from their clients; these negative responses came more from fellow music therapists and colleagues, or from people outside the music therapy profession (such as audiologists). This would indicate that hearing loss need not impede professionalism for music therapists within the clinical setting, but that problems arise, instead, from misunderstanding and judgments from others. Importantly, for those working with deaf clients, the shared experience of hearing loss and the corresponding different way of processing sound may in fact prove valuable in the therapeutic relationship.

The fear of missing something was a common experience in the narratives, inducing feelings of guilt and anxiety in some participants, which could be said to align with existing research on internalised stigma, in which stigma processes may lead to affective responses, such as anxiety and shame (Goffman, 1963; Mendes & Muscatell, 2018, Vogel et al., 2013). Whilst all participants touched on the stigma of hearing loss in their narratives, there were considerable differences in the way that they perceived, experienced and spoke of it. Major et al. (2018), in their exploration into stigma, discrimination and health, point to the contextual nature of stigma, where individuals are believed to possess some attribute that conveys a social identity that is devalued in a particular social context. This would relate to the experiences of one participant who felt judged and 'rejected' by the music therapy community because of his deafness.

The differences in the way some participants felt about or experienced stigma and identity could be congruent with the relational aspect of stigma observed by Jones et al. (1984) in which a condition that may be labelled as deviant by one person may, conversely, be viewed as an intriguing and 'charming eccentricity' by another person. As highlighted in the narratives, some participants felt that people were generally 'intrigued' or 'astonished' by their ability to be a music therapist with a hearing loss, whereas some participants felt devalued and disrespected by others. These are significant findings if we are to consider implications for practice. These opinions, whether positive or not, are still judgements which are likely to come from a place of little understanding. While being thought of as inspirational may not appear to be a negative view, some literature within the disability arena has underlined the contribution of 'inspiration porn' to an erroneous understanding of disabilities, in which 'othering' the disabled person simply accentuates the

stigmatisation (Haller & Preston, 2017). This could correlate with the portrayal and understanding of hearing loss, whereby the focus may often be on the burden of the impairment rather than on societal obstacles faced by the people experiencing hearing loss. As such, disseminating information about the experiences of music therapists with hearing loss, via training, conference presentations or journal articles, could be a valuable and important step towards more acceptance and understanding and could perhaps also be a move towards encouraging more deaf people to consider entering the profession. Input from d/Deaf musicians and music therapists in devising the training should be of paramount importance here.

There were no clear links to be made between participants' confidence levels and the onset of their hearing loss. This does not reflect recent research which concluded that acquired hearing loss in adulthood leads to more psychological trauma than living with hearing loss from the early years of life (Sebastian et al., 2015), although the small sample size in the current study may account for this. It was notable that participants here expressed a broad and complex range of experiences that sometimes did not bear any relation to the onset or severity of their hearing loss. In fact, close analysis of the narratives showed that this diversity in personal confidence with regard to identity appeared to be predominantly linked with the levels at which participants felt accepted and respected by others. This concept is echoed in disability studies literature, which looks at the personal experience of disability and the extent to which experiences are shaped by societal, political and cultural levels of acceptance (Goodley, 2017; Riddell & Watson, 2014).

As an invisible impairment, hearing loss invites a complex dimension: the potential for denial of the impairment (Santuzzi et al., 2015). Whilst none of the participants denied their hearing loss, there were different responses with regard to the level at which they believed or accepted that it was a disability, ranging from not thinking of hearing loss as a disability at all, to talking frankly about being disabled and the need for openness and acceptance. Responses also varied with regard to disclosure of hearing loss to clients. There were no discernible links between disclosure decisions and severity of hearing loss. Some participants did not disclose their hearing loss to clients in the clinical setting. One participant, who openly introduced ear defenders into sessions, was clear and passionate about the need to protect hearing. The different approaches reflect research by Southall et al. (2011), in which factors that influence disclosure of hearing loss in the workplace were explored, including stigma and implications for practice. The primary theme that emerged in the findings was centred on the perceived sense of control, which could be said to echo the responses in this current study.

In order to maintain proficiency in clinical work, some participants spoke of the practical elements they needed to consider, such as: positioning in the room, appropriateness of the clinical space for both client and therapist (Jackson, 2018), choice of client group, methods of musical communication and choice of hearing protection. Distinctions between working with individuals and in groups were also acknowledged, including the barriers to focused listening that may arise in group situations due to the difficulties in discerning layers of sound. Other less tangible barriers to proficiency were also expressed by participants. For example, for two participants who were experiencing a gradual decline in their hearing, there was an added element of concern for the future when considering their personal competence in the profession (Beach & Gilliver, 2015; Chesky, 2008). Other areas of concern expressed in the narratives were: levels of fatigue, fear of missing significant

moments, lack of directional hearing, adjustment processes and confidence levels.

Given the emphasis placed by all six participants on the protection of their remaining hearing, alongside recent research highlighting the potential for music therapy work to cause noise-induced hearing loss (MacMahon, 2015), the issue of hearing protection feels of paramount importance within the music therapy field, and is currently little acknowledged. The improvisational nature of music therapy (Bunt & Stige, 2014; Oldfield, 2006; Wigram, 2004) means that the chance for sudden, impulsive noise within a clinical music therapy session is elevated, giving even more reason to raise awareness of the dangers. Thus, the dissemination of information about hearing loss and the introduction of hearing-protection training could perhaps be recommended as part of music therapy training before entering the profession (O'Brien et al., 2014; Walter, 2017). In addition, education around hearing aids and assistive technologies is needed, especially with regard to the specifics of listening and the different ways that a musician may hear, interpret and understand sounds.

Limitations

Whilst the participants did not identify with Deaf culture or the Deaf community and all communicated using spoken English, some talked about their experiences of deafness, including reflections on Deaf culture and music. One participant had felt negatively judged due to being born deaf but not embracing Deaf culture; another talked of 'anti-music Deaf signers.' The potential for deeper exploration into this was considerable, especially with regard to exploring views and attitudes held within the Deaf community towards music therapy (Ward, 2016). Unfortunately, this subject was beyond the scope of a study of this size. Future research and analysis could explore this area further.

Having an 'insider status' as a music therapist with tinnitus could be seen as a limitation, in that questions may arise as to whether the interpretation of the analysis reflected personal subjectivity (Corbin-Dwyer & Buckle, 2009). This was particularly relevant when exploring the data of music therapists with tinnitus and high-frequency hearing loss. The heightened level of researcher subjectivity could potentially be seen as detrimental to data analysis. However, being an 'insider' could, conversely, be seen as a positive researcher stance in that it was possible to get closer to some participants' experiences, relate to the feelings expressed, and potentially connect more deeply with the data.

Methodological limitations should also be acknowledged. All hearing loss was self-reported, rather than verified using audiometric data. We also acknowledge that this study lacks transferability due to each music therapist's experience of hearing loss being so unique. However, it is hoped that the identification and presentation of unifying themes across the data has done justice to the rich and diverse experiences of the participants and, as this is currently the only study in this area, that the implications could have some reach.

CONCLUSION AND FUTURE RECOMMENDATIONS

This study has shown that it is possible to be a professional, proficient music therapist with hearing loss, and that neither congenital nor acquired hearing loss need impede ability to practise in this field. However, there are areas from which barriers to proficiency may arise. These areas include:

levels of awareness and understanding from others, appropriateness of client group, adjustment processes (to loss of hearing, hearing aids, assistive technologies and hearing protection), management of clinical space, and levels of confidence.

Given the potential for sounds created during clinical work to damage hearing for music therapists and the emphasis placed on the protection of remaining hearing by the participants, it is hoped that this study has opened up the potential for more research in the area of music therapy and hearing loss. Crucially, the introduction of hearing-protection training within music therapy programmes is recommended for trainees before entering the music therapy profession.

REFERENCES

Arnason, C. (2003). Music therapists' listening perspectives in improvisational music therapy. *Nordic Journal of Music Therapy, 12*(2), 124-138. https://doi.org/10.1080/08098130309478083

Abrams, B. (2011). Understanding music as a temporal-aesthetic way of being: Implications for a general theory of music therapy. *The Arts in Psychotherapy 38*(2), 114-119.

Baldridge, D.C., & Kulkarni, M. (2017). The shaping of sustainable careers post hearing loss: Toward greater understanding of adult onset disability, disability identity, and career transitions. *Human Relations*, *70*(10) 1217-1236. https://doi.org/10.1177/0018726716687388

Bang, C. (2009). A world of sound and music: Music therapy for deaf, hearing impaired and multi-handicapped children and adolescents. Multimedia documentation review. *Approaches: Music Therapy and Special Music Education 1*(2), 93-103. http://approaches.gr/wp-content/uploads/2015/09/Approaches_122009_Bang_Review.pdf

Bathurst, Bella. (2017). *Sound: A story of hearing lost and found.* Profile Books Ltd.

Beach, E., & Gilliver, M. (2015). Instrumental music teachers: Music exposure and hearing loss. *Australian Journal of Music Education, 1,* 3-12.

Beck, D. L. (2014). Issues and considerations regarding musicians, music, hearing and listening. *Hearing Review, 21*(8), 14-16.

Berg, A., Ibrahim, H., Sandler, S., & Salbod, S. (2016). Music-induced hearing loss: What do college students know? *Contemporary Issues in Communication Science and Disorders*, *43*, 195-205. http://doi.org/10.1044/cicsd_43_F_195

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.

Bunt, L., & Hoskyns, S. (Eds.). (2002). *The handbook of music therapy*. Routledge.

Chasin, M. (2009). *Hearing loss in musicians. Prevention and management.* Plural Publishing Inc.

Bunt, L., & Stige, B. (2014). *Music therapy: An art beyond words* (2nd ed.). Routledge.

Chesky, K. (2008) Preventing music-induced hearing loss. *Music Educators Journal, 94*, 36-41. https://doi.org/10.1177/002743210809400308

Clifford, R.E., & Rogers, R. A. (2009). Impulse noise. Theoretical solutions to the quandary of cochlear protection. *Annals of Otology, Rhinology & Laryngology, 118*(6), 417-427. https://doi.org/10.1177/000348940911800604

Corbin-Dwyer, S. and Buckle, J.L. (2009). The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Methods, 8*(1), 54-63. https://doi.org/10.1177/160940690900800105

Dalebout, S. (2009). *The Praeger guide to hearing and hearing loss. Assessment, treatment and prevention.* Praeger Publishers.

Darrow, A. (2006). The role of music in Deaf culture: Deaf students' perception of emotion in music. *Journal of Music Therapy, 43*(1), 2-15. https://doi.org/10.1093/jmt/43.1.2

Darrow, A.A., Gfeller, K.E., Gorusch, A., and Thomas, K. (2000). Music therapy with children who are deaf and hard-of-hearing. In C.E. Furman (Ed.), *Effectiveness of music therapy procedures: Documentation of research and clinical practice* (3rd ed., pp. 135–157). American Music Therapy Association.

Darrow, A. A., & Tsiris, G. (2013). Music therapy and special music education: Interdisciplinary dialogues. *Approaches: Music Therapy and Special Music Education, 5*(1), 13-17. http://approaches.gr/wp-content/uploads/2015/09/6-Approaches_512013_Darrow-Tsiris_Interview.pdf

Desjardins, J.L. (2016). The effects of hearing aid directional microphone and noise reduction processing on listening effort in older adults with hearing loss. *Journal of the American Academy of Audiology*, 27, 29-41. http://doi.org/10.3766/jaaa.15030

Di Stadio, A. (2017). Which factors to induce hearing loss in professional musicians? Extensive literature review and histopathology findings can answer it. *Hearing, Balance and Communication, 15*(2), 63-71. http://doi/.org/10.1080/21695717.2017.1311505

Eatough, V., & Smith, J. (2010). 'I was like a wild wild person': Understanding feelings of anger using interpretative phenomenological analysis. *British Journal of Psychiatry, 97*(4), 483-498. http://doi.org/10.1348/000712606X97831

Edwards, J. (2016). *The Oxford handbook of music therapy*. Oxford University Press.

Einhorn, R. (2012). Observations from a musician with hearing loss. *Trends in Amplification, 16*(3), 179-182. http://doi.org/10.1177/1084713812468513

Foss, K. (2014). (De)stigmatizing the silent epidemic: Representations of hearing loss in entertainment television. *Health Communication, 29*, 888-900. http://doi.org/10.1080/10410236.2013.814079

Freeman, M. (2008). Hermeneutics. In L. M. Given (Ed.), *The sage encyclopedia of qualitative research methods* (pp. 385-388). Sage.

Fulford, R, Ginsburg, J., & Golbert, J. (2011). Learning not to listen: The experiences of musicians with hearing impairments. *Music Education Research*, *13*(4), 447-464. https://doi.org/10.1080/14613808.2011.632086

Fulford, R., & Ginsborg, J. (2014). Can you hear me? Effects of hearing impairments on verbal and non-verbal communication during collaborative musical performance. *Psychology of Music*, *42*(6), 846-855. http://doi.org/10.1177/0305735614545196

Gfeller, K. (2007). Music therapy and hearing loss: A 30-year retrospective. *Music Therapy Perspectives, 25*(2), 100-107. http://doi.org/10.1093/mtp/25.2.100

Goffman, E. (1963). *Stigma: Notes on the management of a spoiled identity*. New Jersey: Prentice Hall Inc.

Gooday, G., & Sayer, K. (2017). *Managing the experience of hearing loss in Britain, 1830 - 1930.* Palgrave Pivot.

Goodley, D. (2017). *Disability studies: An interdisciplinary introduction* (2nd ed.). Sage.

Gro, T. (2016). Self-care in music therapy: The art of balancing. In J. Edwards (Ed.), *The Oxford handbook of music therapy* (pp. 936-956). Oxford University Press.

Haller, B., & Preston, J. (2017). Confirming normalcy: 'Inspiration porn' and the construction of the disabled subject? In K. Ellis & M. Kent (Eds.), *Disability and social media: Global perspectives* (pp. 41-56). Routledge.

Hargreaves, R., Macdonald, R., & Miell, D. (2016). Musical identities. In S. Hallam, I. Cross & M. Thaut (Eds.), *The Oxford handbook of music psychology* (2nd ed., pp. 759-774). Oxford University Press.

Harold, O. (1985). *Adjustment to adult hearing loss*. Taylor and Francis.

Hayes, P. (2013). Noise doses of high school band directors. *Journal of Band Research, 49*(1), 54-70.

Headlam, D. (2006). Learning to hear autistically. In N. Lerner, N & J. Straus (Eds.), *Sounding off: Theorizing disability studies in music* (pp. 109-120). Routledge.

Hearing Aids for Music (2020). http://www.musicandhearingaids.org

Hefferon, K., & Gil-Rodriguez, E. (2011). Interpretive phenomenological analysis. *The Psychologist, 24*(10), 756-764.

Herbst, K. G. (2000). Acquired deafness. In P. Hindley & N. Kitson (Eds.), *Mental health and deafness* (pp. 253-284). Whurr Publishers Ltd.

Jackson, D. (2018). Aesthetics and the psychotherapist's office. *Journal of Clinical Psychology, 74*(2), 233-238. https://doi.org/10.1002/jclp.22576

Jennings, M.B., Southall, K., & Gagne, J. (2013). Social identity management strategies used by workers with acquired hearing loss. *Work*, *46*, 169-180. http://doi.org/10.3233/WOR-131760

Jensen, E., Helleman, H., Dreschler, W., & de Laat, J. (2009). Noise induced hearing loss and other hearing complaints among musicians of symphony orchestras. *International Archives of Occupational Environmental Health*, *82,* 153-164. http://doi.org/10.1007/s00420-008-0317-1

Jones, E. F., Farina, A., Hastorf, A. H., Markus, H., Miller, D. T., & Scott, R. A. (1984). *Social stigma: The psychology of marked relationships.* Freeman.

Khatter, K. (2011). Personal music players and hearing loss: Are we deaf to the risks? *Open Med, 5*(3), 137-138.

King, G. A., Servais, M., Bollack, L., Shepherd, T. A., & Willoughby, C. (2012). Development of a measure to assess effective listening and interactive communication skills in the delivery of children's rehabilitation services. *Disability and Rehabilitation, 34*(6), 459-469. https://doi.org/10.3109/09638288.2011.608143

Ladd, P. (2003). *Understanding Deaf culture: In search of deafhood.* Multilingual Matters Ltd.

Lane, K. R., & Clark, M. K. (2016). Assisting older persons with adjusting to hearing aids. *Clinical Nursing Research, 25*(1), 30-34. http://doi.org/10.1177/1054773814563350

Levitin, D. (2006). *This is your brain on music*. Atlantic Books.

Lysons, K. (1996). *Understanding hearing loss.* Jessica Kingsley Publishers.

MacMahon, L., & Page, A. (2015). Noise induced hearing loss in music therapists: A case study. *Journal of Environmental Health Research., 15*(1), 57-70.

Major, B., Dovidio, J. F., & Link, B. G. (Eds.). (2018). *The Oxford handbook of stigma, discrimination and health*. Oxford University Press.

Malloch, S., & Trevarthen, C. (Eds.). (2009). *Communicative musicality: Exploring the basis of human companionship*. Oxford University Press.

Manchaiah, V., & Danermark, B. (2016). *The experience of hearing loss: Journey through aural rehabilitation*. Routledge.

Mendes, W., & Muscatell, K. (2018). Affective reactions as mediators of the relationship between stigma and health. In B. Major, J. F. Dovidio & B. G. Link (Eds.), *The Oxford handbook of stigma, discrimination and health*. Oxford University Press.

Morata, T. C., Themann, C. L., & Randolph, R. F. (2005). Working in noise with a hearing loss: Perceptions from workers, supervisors and hearing conservation program managers. *Ear Hear, 26*, 529 -545. http://doi.org/10.1097/01.aud.0000188148.97046.b8

Music and the Deaf (2020). http://www.matd.org.uk

Nachtegaal, J., Kuik, D. J., & Anema, J. R. (2009). Hearing status, need for recovery after work and psychosocial work characteristics: Results from an internet-based national survey on hearing. *International Journal of Audiology, 48*, 684-691. http://doi.org/10.1080/14992020902962421

O'Brien, I., Driscoll, T., Williams, W., & Ackermann, B. (2014). A clinical trial of active hearing protection for orchestral musicians. *Journal of Occupational and Environmental Hygiene, 11*(7), 450-459. http://doi.org/10.1080/15459624.2013.875187

Oldfield, A. (2006). *Interactive music therapy: A positive approach. Music therapy at a child development centre.* Jessica Kingsley Publishers.

Reid, K., Flowers, P., & Larkin, M. (2005). Exploring the lived experience. *The Psychologist, 18*, 20-23.

Riddell, S., & Watson, N. (Eds.). (2014). *Disability, culture and identity*. Routledge.

Robbins, C., & Robbins, C. (1980). *Music for hearing impaired and other special groups*. Magnamusic-Baton.

Rudner, M. (2016). Cognitive spare capacity as an index of listening effort. *Ear and Hearing: The Official Journal of the American Auditory Society, 37,* 695-765. http://doi.org/10.1097/AUD.0000000000000302

Sacks, O. (2007). *Musicophilia: Tales of music and the brain.* Pan Macmillan Ltd.

Sacks, O. (1989). *Seeing voices.* Macmillan Publishers Ltd.

Salmon, S. (Ed.). (2008). *Hearing, feeling, playing: Music and movement of hard-of-hearing and deaf children*. Reichert Verlag.

Santuzzi, A. M., Waltz, P. R., Finkelstein, L. M., & Rupp, D. E. (2015). Invisible disabilities: Unique challenges for employees and organisations. *Industrial and Organisational Psychology, 7*(2), 204-219. http://doi/org/10.1111.iops.12134

Schink, T., Kreutz, G., Busch, V., Pigeot, I., & Ahrens, W. (2014). Incidence and relative risk of hearing disorders in professional musicians. *Occupational and Environmental Medicine*, *71*, 472-476. http://doi.org/10.1136/oemed-2014-102172

Sebastian, S., Varghese, A., & Gowri, M. (2015). The impact of hearing loss in the life of adults: A comparison between congenital versus late onset hearing loss. *Indian Journal of Otology, 21*(1), 29-32. http://doi.org/10.4103/0971-7749.152857
Shohet, J. A., & Bent, T. (1998). Hearing loss: The invisible disability. *Postgraduate Medicine*, *104*(3), 81-90. http://doi.org/10.3810/pgm.1998.09.572
Silverman, D. (2014). *Interpreting qualitative data: A guide to the principles of qualitative research.* Sage.
Simmons, M. (2005). *Hearing loss: From stigma to strategy*. Peter Owen Publishers.
Skovholt, T. M. (2012). *Becoming a therapist: On the path to mastery*. John Wiley & Sons Inc.
Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis. Theory, method and research*. Sage.
Smith, J., & Osborn, M. (2003). Interpretative phenomenological analysis. In J.A. Smith (Ed.), *Qualitative psychology: A practical guide to methods* (pp. 53-80). Sage.
Southall, K., Jennings, M. B., & Gagné, J. P. (2011). Factors that influence disclosure of hearing loss in the workplace. *International Journal of Audiology, 50*(10), 699-707. http://doi.org/10.3109/14992027.2011.588963
Starck, J., Toppila, E., & Pyykko, I. (2003). Impulse noise and risk criteria. *Noise and Health. A Bimonthly Interdisciplinary International Journal*. *5*(20), 63-73.
Stern, D. N. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology.* Ingram Publisher Services.
Sutton, J. P. (2007). The air between two hands: Silence, music and communication. In N. Losseff, & J. Doctor (Eds.), *Silence, music, silent music* (pp. 169-186). Ashgate Publishing Limited.
Trevarthen, C. (1997). Preface. In M. Pavlicevic, *Music therapy in context: Music, meaning and relationship* (pp. ix-xii). Jessica Kingsley Publisher https://doi.org/10.1080/08098130009477996
Trevarthen, C., & Malloch, S. (2000). The dance of wellbeing: Defining the musical therapeutic effect. *Nordic Journal of Music Therapy, 9*, 3-17. http://doi.org/10.1080/08098130009477996
Vogel. D.L., Bitman, R.L., Hammer, J.H., & Wade, N. (2013). Is stigma internalised? The longitude impact of public stigma on self-stigma. *Journal of Counseling Psychology, 60*(2) 311-316. http://doi.org/10.1037/a0031889
Wallhagen, M. (2009). The stigma of hearing loss. *The Gerontologist, 50*(1), 66-75. http://doi.org/10.1093/geront/gnp107
Walter, J. (2017). Earplug usage in preservice music teachers. *National Association for Music Education, 35*(2), 5-14. http://doi.org/10.1177/8755123315603108
Ward, A.J. (2016). Music therapy interventions for Deaf clients with dual diagnosis. *Voices: A World Forum for Music Therapy*, *16*(3), 1-10. https://doi.org/10.15845/voices.v16i3.840
World Health Organisation (WHO) (2020). http://www.who.int/news-room/fact-sheets/detail/deafness-and-hearing-loss
Wigram, T. (2004). *Improvisation: Methods and techniques for music therapy clinicians, educators and students*. Jessica Kingsley Publishers.
Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, *15*(2), 215-228. https://doi.org/10.1080/08870440008400302

Ελληνική περίληψη | Greek abstract

***‘Είναι απλώς μία διαφορετική διάσταση’*: Οι εμπειρίες μουσικοθεραπευτών με απώλεια ακοής**

Sara Cole | Catherine Warner

ΠΕΡΙΛΗΨΗ

Η παρούσα μελέτη διερευνά την ζώσα εμπειρία πιστοποιημένων μουσικοθεραπευτών που αναγνωρίζουν ότι έχουν απώλεια ακοής. Ο κίνδυνος απώλειας της ακοής στους επαγγελματίες μουσικούς είναι ευρέως αναγνωρισμένος στη βιβλιογραφία, και μία μελέτη επικεντρώνεται στον αυξημένο κίνδυνο απώλειας της ακοής των μουσικοθεραπευτών. Όμως, δεν υπάρχουν μελέτες στη βιβλιογραφία που να διερευνούν το βίωμα της απώλειας της ακοής από την οπτική του μουσικοθεραπευτή, σε ένα επάγγελμα που η ακοή και η ακρόαση είναι κομβικής σημασίας για την δουλειά τους. Στη μελέτη αυτή χρησιμοποιήθηκαν ποιοτικές μέθοδοι έρευνας, με τη χρήση ημι-δομημένων συνεντεύξεων με έξι μουσικοθεραπευτές που βιώνουν σε διαφορετικά επίπεδα απώλεια ακοής. Οι μεταγραμμένες συνεντεύξεις αναλύθηκαν μέσω ερμηνευτικής φαινομενολογικής ανάλυσης [Interpretative Phenomenological Analysis, IPA], από όπου προέκυψαν τρεις βασικές θεματικές κατηγορίες: 1) Η ακρόαση είναι εξουθενωτική: η ταυτότητα του μουσικοθεραπευτή με απώλεια ακοής· 2) Ανυπόμονος ή περίεργος; Στίγμα έναντι υποστήριξης· και 3) Πώς το αντιμετωπίζω: στρατηγικές διαχείρισης. Αυτές οι θεματικές αναλύονται σε βάθος, υπό το πρίσμα της υπάρχουσας θεωρίας και των επιπτώσεων στην πράξη. Τα αποτελέσματα υποστηρίζουν τα υπάρχοντα ερευνητικά δεδομένα

ενισχύοντας ότι η επίκτητη απώλεια ακοής δεν παρεμποδίζει τη μουσική ικανότητα. Εμπόδια επαγγελματικής επάρκειας προκύπτουν από άλλους τομείς. Στη συζήτηση των συνεπειών συμπεριλαμβάνονται συστάσεις ως προς την εκπαίδευση για την προστασία της ακοής μέσα στο πλαίσιο των σπουδών μουσικοθεραπείας.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ
απώλεια ακοής, μουσικοθεραπεία, ταυτότητα, στίγμα, προστασία ακοής, η υγεία του μουσικού

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APPROACHES

INTERVIEW

"Music to the ear": An interview with Paul Whittaker

Paul Whittaker
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Shirley Salmon
Mozarteum University Salzburg, Austria

ABSTRACT

Paul Whittaker is a profoundly deaf musician who has devoted his life to encouraging other deaf people to engage with music and challenging others to think about how they hear and perceive music. In this interview with Shirley Salmon, he talks about his background and experiences and some of the difficulties he has faced.

KEYWORDS

music,
deafness,
perception of music,
hearing loss

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AUTHOR BIOGRAPHIES

Paul Whittaker was born in Huddersfield in 1964 and has been deaf all his life. After getting a music degree from Wadham College, Oxford and a post-graduate diploma from the RNCM, he founded Music and the Deaf, a charity he ran for 27 years before leaving to pursue a freelance career. Paul has signed many shows and concerts across the UK, including with The Sixteen and at the BBC Proms. He continues to promote music and deafness and currently runs seven signing choirs. He was awarded an OBE in 2007 and holds two Honorary Degrees. [paul@paulwhittaker.org.uk] **Shirley Salmon** MPhil, PGCE, BA, taught music and movement to deaf and hard-of-hearing children for many years and has published on this topic. She has lectured at the Orff-Institute, Mozarteum University Salzburg, focussing on Music in the Community and Inclusive Pedagogy since 1984. She is president of the International Orff-Schulwerk Forum Salzburg. [sdaysalmon@gmail.com]

Note: This interview took place through a series of email exchanges starting in January 2019 when the idea of an interview was first proposed.

Shirley Salmon: What was your first contact with music? What memories are especially important for you?

Paul Whittaker: I grew up in a musical household, despite being born deaf. My mum played the piano and both parents enjoyed listening to music, so the radio was always on and records were being played. I was also taken to church from a young age so must have been aware of music there, though I don't actually recall any specific pieces from that time.

I can remember that the four records I liked playing most when I was little were: "I'm Down" by the Beatles (the B side of "Help"), "Moses Supposes" (from the "Singin' in the Rain" film soundtrack),

a Max Bygraves recording of "Tulips from Amsterdam," and the first movement of Beethoven's "Moonlight Sonata," played by Solomon. That was a fairly eclectic collection for a very young child!

When I was five years old, I began having piano lessons and two years later I joined my local church choir. I don't recall any difficulties with either of those things though; with hindsight, I suppose it must have been rather more daunting for the teacher and the choirmaster than it was for me, faced as they were with someone who couldn't hear. If there were any issues they never complained (to me at least).

I can still remember various simple pieces from my first piano book, but the most vivid musical memory as a youngster comes from when I was about eight years old, when the "West Side Story" film was on TV one Sunday night. I didn't stay up to watch it all, yet some of the music – particularly the balcony scene with Tony and Maria – really grabbed my attention. As the years went on, I got to know the whole score in detail and was privileged to be the sign language interpreter for the 50th Anniversary UK theatre tour. It's still one of my favourite pieces of music – a work of genius – and I met Leonard Bernstein in 1986 and Stephen Sondheim in 2010, two events fixed in my memory.

From the ages of seven to 12, I was immersed in sacred music, I suppose through being in the church choir, and a love of that repertoire has stayed with me. Being a chorister is a superb musical education, with three rehearsals each week and two services on a Sunday. A choir also gives you the joy of making and sharing music with others; it's fun to do music alone, but far more fun to do it with others.

It was through the choir that I became interested in playing the organ, which I started when I was 12. I wanted to start earlier but was told it wasn't possible as my legs were not long enough and also I didn't have my Grade 5 piano exam! When I finally did start lessons, they were on a huge five-manual instrument in Wakefield Cathedral. Shortly after that I started playing for services; by the time I was 14, I was playing for four different services in three churches every Sunday, one of which I was choirmaster at as well.

Of all the instruments for a deaf person to play, I'd say the organ is one of the hardest. With a piano you depress a key, the hammer hits the string, the vibrations travel back up your arm, and every note feels different; with a string instrument, you apply the pressure of a bow on the strings; with wind and brass, you control the flow of air; but with an organ, you switch the blower on, pull out a stop, press a key, and sound is produced from a distant location. It's far harder to feel the vibrations with an organ, and you're usually separate from the sound source and dealing with a challenging acoustic. Despite this, I do love playing the organ but always need someone to tell me if I am using an appropriate registration and playing for the acoustics of the building.

Shirley: I find it remarkable that you had so much exposure to music and could experience many aspects of music. How did you perceive your deafness growing up?

Paul: To be honest, I never gave it much thought at all. I've always felt it is far easier to cope with any kind of disability if you have it from birth or from a young age. With hindsight, I realise that I probably did miss a lot of information when I was growing up, but it didn't bother me at all at the time.

Being born with a hearing loss, I have no detailed aural memory of music – I could hear certain sounds but these were distorted – but there must be sounds that my subconscious retains and recalls.

Until the age of seven, my hearing loss remained fairly stable, but it deteriorated rapidly over the next four years and by the age of 11 I was classed as Profoundly Deaf.

When I was 12, I decided that when I grew up I wanted to help and encourage other deaf people to make and enjoy music and, prior to that, wanted to get a music degree from somewhere. This was when I first started to encounter resistance and prejudice towards my deafness.

Over a two-year period, I applied to 12 Universities and was rejected by all of them, despite already having three music diplomas: their view was quite simply that deaf people couldn't possibly be musicians. Eventually, in 1983, I was accepted by Wadham College, Oxford, and spent three wonderful years there in an environment that couldn't have been more supportive and helpful. In many ways the Oxford music course was ideal for me, as tutorials took place in either a one-to-one or two-to-one basis and lectures were given in fairly small groups and rooms, so communication was never a major problem.

I've been fortunate in not coming across too many blatant examples of prejudice in my life and the best way to deal with it is to prove people wrong. Looking back, I am very proud of what I have achieved. I know I've changed the lives of many people by introducing them to music, and being awarded two honorary degrees and an OBE for services to music shows I must have done something right!

Shirley: It was very fortunate that you eventually got a place to study music in a supportive environment. Of course, it is impossible for me as a person with hearing to imagine how you, as a Deaf person, hear music. Can you describe your perception of music?

Paul: Until I went to Oxford, I never actually considered how I heard and understood music; I had always been deaf and always been a musician, so it was a perfectly normal thing for me to be doing. Even now I can't really explain my musical skills and knowledge, analyse exactly how I conduct a choir, or describe why I enjoy going to concerts. *How* I do it isn't important to me, but it obviously is to others, who love to ask me questions about it.

For example, I was once asked if the clothes I wear make a difference when listening to – or, more correctly, perceiving – music. I'd never considered this at all and, at the time, I could not give a reply. Having thought about it since, the answer must be "yes" because the more heavily clothed I am the less sensitive to vibration I become, though it's still debatable how much of a difference it actually makes.

What I can confidently say is that I rely entirely on two things – vibration and score-reading – and that being a pianist helps tremendously. With a piano you have a huge range of pitch and a very physical instrument, plus the need to read both treble and bass staves. As I explained earlier, you feel the vibrations of each note travel up your arm and through your body and, over time, develop a physical sense of pitch. With my hearing aids, I can pick up about five octaves from the bottom of the piano, but knowing what those notes are, and the music they create, is only possible when I see the score. Without my hearing aids, I can't hear a single note.

As for 'hearing' other instruments, there is wide variation. A violin is totally inaudible most of the time, the exception being the very lowest notes. A cello is pretty good, at least in the lower register, because its pitch lies within my best residual hearing range. The woodwind family is, in general, fairly

easy to perceive; the clarinet is best because of the clarity of its tone (especially the warmth of its lower register) and the lowest range of the flute is also very appealing. I find brass instruments hard to perceive, even within an orchestral mass, with the possible exception of French horns. I dislike brass bands because the homogeneity of sound means there is no variety in the colour, tone, or texture of sound, so it's very boring to me. Despite being struck, percussion instruments vary widely in terms of what I can hear: timpani are obviously great, but triangles, cymbals, and tambourines are largely inaudible.

Score reading is something I don't recall ever being taught and from a young age I've been able to follow them without much effort. When I was at university, my tutor and I once discussed this. He told me one day that I was the easiest student he'd ever taught, and that was because of my deafness and, therefore, my reliance on reading a score. I responded by commenting that surely all music students could read a score and found it unbelievable that most, apparently, cannot do so. It's such a fundamental thing to me that I suppose I just assumed that everyone could do it.

Shirley: It is interesting to hear that your perception of different instruments varies so much. Do you think it is possible for people with hearing to understand how deaf people perceive music?

Paul: Hmm, that's a tricky question. My answer has to be: "partly, but you can never really understand and appreciate it because you're not deaf."

Ruth Montgomery, a deaf flute player, has said, "Music is not about hearing any more than language is," (cited in Fulford et al., 2011, p. 448) which makes the point that music is so much more than just hearing. It is a way of communicating with other people and expressing yourself, not just because we need to interact with other human beings, but because it is creative and intrinsically rewarding.

Another deaf musician believes, "I think musicality is something that exists irrespective of hearing" (Liz Varlow, personal comment in Fulford et al., 2011, p. 448). This sounds like a big philosophical statement, but there are clear scientific reasons why it is true. The way we understand music is much more complicated than our hearing mechanism. Music can remain unaffected by appalling cases of physical or mental health, where singing or playing music can be the only things that a person can either remember how to do or, indeed, the only way they can communicate.

Oliver Sacks' book *Musicophilia* (Sacks, 2007) and Dan Levitin's *This is Your Brain on Music* (Levitin, 2007) contain many stories that demonstrate how music is processed in many different parts of the brain. It should be no surprise that our ability to hear (with ears) does not have a great effect on our ability to be musical. What is more surprising (and frustrating) is the persistent idea that a "deaf musician" is a contradiction in terms.

On Evelyn Glennie's website (Glennie, 2020; see Fulford, 2013), we read:

> The definitions of the category 'deaf' – i.e. not being able to hear sound - and the category of music - which is sound - are mutually exclusive. My career, like that of Beethoven and a number of others, is an impossibility. There are only 3 possible explanations, I am not a musician, I am not deaf or the categories of music and deaf must be incorrect.

Evelyn is right. Just because someone is deaf doesn't mean they hear nothing and that's especially true today with cochlear implants and hearing aid technology, although neither are fantastic for listening to music. Music is much more than what we perceive with our ears. People who lose their hearing later in life do not lose their musical abilities. People who are born profoundly deaf may still have an inner sense that they are musical. They may want to learn about music, they may find that they are good at music, and they may then grow up to identify as musicians.

The necessity of seeing the printed music in front of me often prompts people to ask why I bother going to concerts, what the attraction is in paying money to sit in a concert hall reading a score and not hearing the performance in progress. I admit that sometimes I do read the score and ignore the performance, particularly if I am listening to a work for the first time and do not have enough knowledge or memory of the score to concentrate on the sounds coming from the platform. If, however, I go and listen to a work where I do have knowledge of the score, I put the vibrations I perceive together with my own internal vibrations arising from what I see on the page before me and thus detect differences in interpretation.

Shirley: I think it is true that many people still only associate hearing with what we perceive through our ears. Are there some types of music that are difficult for you access?

Paul: Being deaf and so relying on the notated score does cut me off from some kinds of music. Electronic and avant-garde are major no-go areas, as the use of unconventional notations means that I cannot even get a visual impression of the music. Improvised music naturally presents difficulties and, although I enjoy Jazz, I can only perceive rhythmic variations not melodic ones.

Having to rely on the score does sometimes frustrate me. Without a score it is impossible for me to understand and enjoy a piece of music, but actually buying them is expensive and not every piece of music is available in print anyway. Even with a score it's not always easy to follow it in a confined space, in a concert hall, with people sat on either side and in front, and good lighting cannot be guaranteed!

Occasionally I am asked about other challenges. Conducting an orchestra (or some other group of instrumentalists) is an obvious one, yet I'd love to have a go, simply for the experience. Certain playing techniques or the use of unusual tunings are other barriers. The musician in me always wants to know what a composer is trying to say or express but there are times when I have to accept that it's just not going to be possible, and gracefully accept defeat.

Shirley: You have a strong musical background and training that has given you access to many types of music. From my experience, living for a long time in Austria, it is rare for children who are deaf to have access to music education at school in comparison to children who are not deaf. Your background was obviously a big influence in establishing Music and the Deaf (MatD). Can you tell us more about it?

Paul: This was the charity that I founded in 1988 and ran for 27 years, before leaving in 2015 to pursue a freelance career.

As I mentioned earlier, when I was 12 years old, I had this idea of finding ways of helping and encouraging deaf people to both enjoy and make music as I did. The initial vision was to have an actual building where we would run courses and classes of all kinds, along with staff who would work across the UK to lead and establish projects.

As I got older, I realised that this was an expensive idea! Instead I did all the work – going out speaking, leading workshops, devising, collaborating on projects with other arts organisations, and doing signed theatre and concert work – and, as time went on, found others to assist with both the delivery and the admin of it all. There was certainly plenty of doubt from others, but I knew it could succeed, and it did.

The main aims were, very simply, to encourage and support deaf people – and those who live and work with them – to make music. I was never bothered about someone's degree of deafness, their communication method, whether someone wore hearing aids or not, or the age of anyone; I just wanted to find ways of making music and educating society at large about music and deafness.

There was never really any clear plan or strategy; it was very much running with an idea and finding like-minded people to achieve it. As well as working with deaf people, it was vital to educate hearing people about music and deafness, as they were the ones who controlled, for example, education policies, schools, music colleges, budgets, arts venues, and organisations.

Within the Deaf community itself there were big challenges. For older people – many of whom had for decades been banned from using sign language and forced to learn to speak – music was a very negative thing as, in their minds and experiences, it was inextricably linked to speech therapy and therefore 'bad.' There was also what I'll call the 'political' brigade who saw music as a purely hearing thing and made no secret of their distaste for it in a 'Deaf world.' Each to their own, but there should always be tolerance and respect.

Shirley: You ran the charity MatD for 27 years and have encouraged and supported deaf people to access and make music. What are you focussing on now?

Paul: With the exception of music workshops, which I very rarely do now (with one exception that I'll mention in a moment), I still do talks, motivational speaking, and some signed theatre and concert performances, but my main area of work has become signed song. I currently lead seven sign language choirs, advise a few others, create lots of resources, and work with various music organisations to develop this skill.

It is good that arts organisations are becoming more aware of diversity and accessibility, and actually taking it seriously. For too long it was merely a box-ticking exercise (and, for some, it still is), but the general trend has been positive.

It's frustrating, however, when organisations and venues use interpreters, project leaders, whatever, who are hearing and do not have the music skills and knowledge required for the job. I see this a part of a wider obsession with qualifications rather than with competence and experience. If you're doing a music and deafness project, you need a deaf musician to help you deliver it!

For the past nine years I've been very fortunate to work with the Mahler Chamber Orchestra (MCO) on their "Feel the Music" project (https://mahlerchamber.com/learning/education-and-outreach/feel-the-music-programme), leading workshops and bringing music to deaf children in

various countries around Europe and further afield. This has been a great joy for everyone involved and has become a fundamental part of the MCO's programming.

During the Covid-19 pandemic, when singing has been discouraged, I've actively promoted signed song as an alternative, and this had been widely welcomed by many. I've made over 200 videos for various choirs, schools, music services, and arts companies, and done projects with the Stay at Home Choir, Oxford Bach Soloists, London Symphony Chorus, Chorus of Scottish Chamber Orchestra, and many others. Hopefully, this will continue once concert life begins again.

Shirley: Your experience and background, as well as the information you have given about the perception of music, have potential implications for music teachers, music therapists, and musicians working with deaf children and adults. What information do you think they might need and what advice would you give them?

Paul: I'm curious as to what these implications might be! Hopefully I challenge – in a positive way – the way they think about music and process it. My experiences have shown me that many teachers are nervous, even scared, of having a pupil who is different (in whatever way) and that reaction is almost always prompted by fear. For some it's been the lack of control or authority that frightens them; yet every pupil, every fellow musician we meet, should really be seen as an opportunity to think afresh about our view of music, how we respond to it, how we make it.

Obviously, if you want to find out what a deaf person thinks of music and how they process it, find one and ask them. It may sound harsh, but there is no way that a hearing person can ever really know what it is like to be deaf and every single deaf person will process and enjoy music in a different way, just as every hearing person does. The 'one size fits all' approach to music education, music therapy or community music is lazy, unhelpful, and potentially damaging. I've encountered far too many young deaf people who have wished to pursue music but whose hopes have been thwarted by the negative and intransigent attitude of examination boards, for example. It has to stop.

Be open; be inquisitive; explore musical journeys and ideas alongside your pupils, not as a superior but as a friend; be challenged; admit you don't always get everything right!

Shirley: Is there anything else you would like to add?

Paul: The most common question I am asked is, "How do you hear music?" and I've developed the habit of turning the question round and responding, "What is music? How would you explain it to someone who can't hear?"

The usual answer to that is silence as, for most people, they rarely stop and think about it. Music is something that goes in one ear and out the other, they know what they like and what they don't like but haven't really thought about what it is. Eventually they might try and explain it by talking about pitch or melody or vibration or emotion. I've had two great answers to this question that I'd like to share with you.

In one MCO project I asked this question to one of the players who immediately responded by saying, "I can't tell you, but I can show you," and did just that. His point was that music isn't something

we explain, it's something that we do; we make it, play it, share it, and it moves us.

The other answer came in the Autumn of 2020. I had filmed some songs in British Sign Language for a school in the UK to learn, and the pupils sent me 'Thank you' cards and letters to show their appreciation. Among them was a drawing which included the words, "You hear best with your heart, not with your ears." I couldn't agree more.

I'm also often asked if I feel I would be a better musician if I could hear, to which I reply, "I doubt it." Obviously, being born deaf I have nothing to compare this to, so anything I say is speculative. If I could hear then maybe conducting an orchestra or ensemble would be more possible, as would accompanying someone. Communal music-making might be less tiring as I would not have the same pressure and strain of lip-reading and watching all the time.

On the other hand, if I could hear then perhaps my understanding of music may be reduced. If I had been able to hear in the past, then I doubt I'd have developed the awareness and appreciation of music that has come from having to get to know music from the printed page. My deafness makes me who I am and whilst I'm not proud of being deaf (it's hard work!) it defines me and is a fundamental part of me.

Being deaf is not a barrier to the enjoyment and appreciation of music, as many would believe. A way over and around every barrier can be found with determination and effort. Thankfully, people no longer tell me that I am "too deaf to do music." I have discovered my own way of 'doing' it: it may not always be what others understand as 'music' but it is far from the sound of silence that they may think it is.

Shirley: Thank you for the interview.

REFERENCES

Fulford, R. (2013). The formation and development of musical identities with a hearing impairment. In M. Stakelum (Ed.), *Developing the musician* (pp. 45-62). Ashgate.

Fulford, R., Ginsborg, J., & Goldbart, J. (2011). Learning not to listen: The experiences of musicians with hearing impairments. *Music Education Research*, *13*(4), 447-464. http://dx.doi.org/10.1080/14613808.2011.632086

Glennie, E. (2020). *Evelyn Glennie: Teach the world to listen.* https://www.evelyn.co.uk/

Levitin, D.J. (2007). *This is your brain on music: The science of a human obsession.* Plume.

Sacks, O. (2007). *Musicophilia: Tales of music and the brain*. MacMillan.

Ελληνική περίληψη | Greek abstract

«Ηχεί σαν μουσική στα αυτιά»: Μία συνέντευξη με τον Paul Whittaker

Paul Whittaker | Shirley Salmon

ΠΕΡΙΛΗΨΗ

Ο Paul Whittaker είναι ένας κωφός μουσικός με βαριά βαρηκοΐα που έχει αφιερώσει τη ζωή του στο να ενθαρρύνει άλλα κωφά άτομα να ασχοληθούν με τη μουσική και στο να προσκαλεί τους άλλους να σκέπτονται ως προς τον ίδιο τρόπο που

ακούν και αντιλαμβάνονται. Στην παρούσα συνέντευξη που έδωσε στην Shirley Salmon, μιλάει για το υπόβαθρο και τις εμπειρίες του και για κάποιες από τις δυσκολίες που έχει αντιμετωπίσει.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

μουσική, κώφωση, μουσική αντίληψη, απώλεια ακοής

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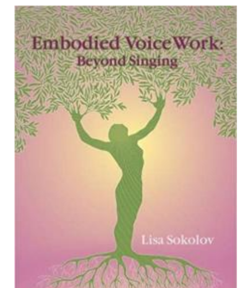
APPROACHES

BOOK REVIEW

Embodied voice work: Beyond singing (Sokolov)



Reviewed by Tina Warnock

Belltree Music Therapy CIC, UK

Title: Embodied voice work: Beyond singing **Author:** Lisa Sokolov **Publication year:** 2020
Publisher: Barcelona Publishers **Pages:** 242 **ISBN:** 978-1-945411- 380

REVIEWER BIOGRAPHY

Tina Warnock is director and clinical lead for Belltree Music Therapy CIC, which she set up in Brighton, UK in 2009. Since 2018 she has been training as a Vocal Psychotherapist with Diane Austin and is the program director for the Vocal Psychotherapy Distance Training Course, based in the UK. Tina is a singer and songwriter alongside her music therapy and clinical supervision practice and has over twenty years' experience working with people of all ages and abilities for Belltree as well as NHS Mental Health and Child Development services. Her publications have focused on voice and identity, and non-verbal voice work. [tinaw@beltree.org.uk]

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Over the past few decades, we have seen a growth in body and voice-related therapeutic interventions, such as Therapeutic Voicework (Newham, 1997), Body Psychotherapy (Totton, 2020), and the development of advanced music therapy models such as Vocal Psychotherapy (Austin, 2008). The importance of the body and voice to our emotional wellbeing is becoming more widely recognised, particularly in the field of trauma theory (Van der Kolk, 2014). So, from the title of this book, "Embodied Voice Work", I was intrigued to see how it would fit in with existing texts and whether it would offer something new and applicable to music therapy practice.

From the beginning, it became clear that this publication held the author's entire life's work – a life that "has been […] immersed in music […] a life of listening, sensing, seeing, singing, teaching and improvising" (p. 4). It also became clear that it was not written specifically for music therapists but for singers, musicians, body workers, teachers, psychologists; anyone who may find the work interesting. The presence of her own poetry, interwoven throughout the book, and the soulful linguistic style sets an ethereal tone for Sokolov's presentation of her method, which she uses in arts education, music therapy and human potential work.

Sokolov begins by sharing her experience as a young person who learned to use her breath and body to manage her own migraine pain, and to begin to support others; she explains how she already identified herself as a musician and singer at a young age, and how this connected her to "something greater" (p. 3).

She presents the core concept behind Embodied Voice Work (EVW), where the whole body is "the human instrument which […] when not fully inhabited […] is not living to its full potential" (p. 4), and EVW as a structure of games that have evolved to open up that instrument. Her descriptions frequently allude to the elements and forces and are full of analogies to natural processes:

> The body is the riverbed, and the breath is the river,
> And the tone is a child's leaf-and-bark boat
> Floating on the currents of the river. (p. 6)

Arranged over twenty-three chapters, this book is well organised and takes the reader through the Foundations, the Fundamentals of the Practice of EVW, Sounding the Body, the Essentials of Music and finally an Overview. Each section is rich with information and spans over thirty pages it is certainly not a book to be read cover to cover in one sitting, if one is to assimilate the content.

In chapters three and four, Sokolov communicates her deep belief that "we are all singers" and that non-verbal singing "frees us from the limits and inhibitions experienced in speaking through words"; it addresses the "individual, physical, energetical, emotional and soul aspects of making sound" (p. 20). She explains how EVW follows the developmental line of verbal communication; we learn to navigate spoken language before learning to read and write and this should be the same with our musical language. Her system of games can be played repeatedly, each time going more deeply "from the general to the essential" (p. 21).

The title of chapter 5 "The Attitude of Listening: Radical Receptivity" really caught my attention, particularly the statement "This work is about listening; that is all. And that is a lot" (p. 30). Here she encapsulates the life-long challenge of every music therapist, to develop their listening skills to ever increasing layers of complexity and develop a truly authentic, compassionate, non-judgmental stance – something that cannot be achieved through reading and researching, but through self-exploration and lived experience. She maps out the different levels of "inner sensing" and a message that becomes a mantra through the book to "Notice what you notice. Feel what you feel. Hear what you hear. Know what you know" (p. 30). This chapter is short but thought provoking and makes the reader aware of the different levels of inner dialogue that we engage in continuously with our mind and body.

A core element of Sokolov's EVW is her developmental warm up which she talks us through in depth in chapter 6 and again in the appendix. This sequential exercise prepares the participant for the work to come. It is a clear example of how her method uses a directive, structured approach to provide a safe framework within which people can explore using the five tools: breath, tone, touch, imagery and improvisation. She then organises the process of EVW into five stages: Exploration, Awareness, Release, A New Balance of Strength and Openness, and Integration and goes on to illustrate how these are experienced in the body. On page 58 there is a useful illustration of how Sokolov perceives the body to be in four quadrants which interact with "energetical landscapes" that she goes later on to define. This term – one of several 'neologisms' used in the book that the author has coined herself – "is a description of a geography of qualities and how they map in the body" (p. 100).

By chapter 9 I found that my motivation to continue reading was occasionally challenged by the abundant abstract analogies, esoteric language and a mantra-like repetition of key messages, almost preaching in style. However, the content was intriguing, and as I read on, I began to get absorbed in the content of the exercises which combine yoga and meditation techniques (the author's knowledge of anatomy and physiology is impressive) with poetry and storytelling, and the essentials of non-verbal voice work; the body as a house with many rooms; resonance profiles;

the path to breath; explorations of vowels and consonants. The detail and level of analysis is captivating and informative.

The Vowel Game in chapter 19 "The Soundscape" is presented as "the deepest game I have developed" (p. 153). My keen interest in non-verbal voice work made this chapter particularly alluring and I found myself following along with my breath and voice to fully absorb what she was attempting to convey with words. Her analysis of how singing vowels "transforms our instrument" (p. 155) was indeed enriching.

Turning to the "Overview", I felt the book was coming to its conclusion. However, there were a further 33 pages of distillation, and some rewording of the previous content. Here the author brings in more poetry and some significant lengthy prose about her stance and philosophical (as opposed to theoretical) backdrop, some case vignettes about and from her students and some specifics about how a session might look. Finally, the appendix with detailed descriptions of her warm-ups and games – a rich resource for people who use directive voice-based activities with individuals or groups.

The absence of references to key psychological theorists in this book may be deliberate, to enable the author to fit her entire method into one volume. However, this made me question the place that Sokolov's work has in the music therapy literature. Her "Supplemental Reading" (p. 225) and acknowledgements towards the end reinforce the feeling that this book, although of potential interest to music therapists, has a much wider reach towards people who seek a deeper knowledge of holistic vocal practice.

To end, I believe this book carries some important messages for music therapists about the potential power in their vocal instruments, and the spectrum of skills needed to engage in compassionate listening: "If we are not willing or able to let our own wide range of human emotions play through us, we are not ready to ask another to do that. This is the work" (p. 176). However, it will sit on a different part of the shelf to books with a more clinical emphasis and stronger theoretical foundation.

REFERENCES

Austin, D. (2008). *The theory and practice of vocal psychotherapy: Songs of the self*. Jessica Kingsley Publishers.

Newham, P. (1997). *Therapeutic voicework: Principles and practice for the use of singing as a therapy.* Jessica Kingsley Publishers.

Totton, T. (2020). *Body psychotherapy for the 21st century*. Confer Books.

Van der Kolk, B. (2014). *The body keeps the score*. Penguin Books.

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BOOK REVIEW

The use of voice in music therapy (Meashey)

Reviewed by Patricia Winter

Radford University, USA

Title: The use of voice in music therapy **Author:** Kelly Meashey **Publication year:** 2020
Publisher: Barcelona Publishers **Pages:** 250 **ISBN:** 978-1-945411533

REVIEWER BIOGRAPHY

Patricia Winter, Ph.D., MT-BC, is the director of the music therapy program and an Associate Professor of music at Radford University in Radford, Virginia, USA. She has been a clinical music therapist for over 20 years serving clients from diverse backgrounds. Her research interests include the impact of music therapy on the development of play skills in young children, pedagogical approaches for educating and training music therapists, and the impact of music therapy for individuals with dementia. [pwinter3@radford.edu]

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Submitted 26 Oct 2020
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As the reviewer of this book, I would be remiss if I did not situate myself in relation to the author. I met Meashey in 1999 as a graduate student at Temple University, Philadelphia, PA. I also came to know Meashey as a well-established Guided Imagery and Music (GIM) fellow with a robust practice in the city. Over the years, I have come to know Meashey as a deeply intuitive musician and music therapist; connected, attuned, thoughtful, and grounded in the art and practice. When I saw that she had written a book about clinical voice, I was eager to read it, and to position myself not only as a university professor tasked with teaching clinical voice, but as a music therapist, and as a classically trained vocalist.

This 250-page text reads like a conversation between the reader and the author. There is a professional tone and a clear commitment to fully uncover the myriad ways that one can use the voice in music therapy, yet it is accessible and personal. Meashey writes for readers with varying degrees of confidence and competence with singing. She offers techniques and strategies for more novice music therapists while ensuring that the writing is not off-putting for more advanced singers, or seasoned music therapists. The text is appropriate for the music therapy classroom and is a great addition to an undergraduate clinical voice class or a graduate level voice class. This book is also an excellent resource for music therapy professionals who wish to continue to develop their singing voice and are looking for new techniques, session ideas, and theoretical approaches for clinical singing. Throughout, Meashey shares her personal experiences with using music to address her own experiences with anxiety and stage fright. These well-placed self-disclosures feel like she is giving the reader permission to look inward to uncover the challenges that can be faced when singing. Meashey highlights the ways that singing is an essential therapeutic approach for clients but can also be implemented to address challenges faced by singers. In Chapter 3, Meashey, broaches the topic of burnout, sharing that she has had moments of resistance and struggle while singing. Her choice to positioning the possibility of burnout early in the text seems meaningful and important.

Meashey's commitment to clinical work can be observed throughout the book as every chapter and section is full of rich and relevant clinical examples, establishing and highlighting her extensive clinical experiences and granting her status as an expert on the topic. What is most beautiful and refreshing about this text is that it is wholly and completely about singing in a music therapy context. Meashey writes about clients, relationships, collaboration, and the importance of understanding both the context of the client and of the therapist in order to implement singing for clinical outcomes. She recognises that singing in a music therapy session is at times not as aesthetic as it is in a performance situation. Within the first seven chapters she focuses on the needs of music therapists and engages in an open dialogue about situations that may contribute to feelings of fear and intimidation for music therapists who are singing with clients. Throughout she assures the reader that if one is working in collaboration with the client to address clinical goals, then implementing a variety of vocal techniques and sounds are indicated even if they do not meet defined aesthetic standards. Meashey offers an example from a client who was non-verbal with severe mental disabilities who cried and wailed. Meashey's approach was to cry and wail along with the client as she joined the client's world. "I wailed with her. It felt agonising, but I couldn't ignore Susie's plea" (p. 31).

It is evident that client and music are the focus of this book as Meashey provides song suggestions, quotes from songs, examples of how music was implemented in sessions, and examples of music composed by the author for clinical use. These musical examples will be quite familiar to a music therapist practicing in the U.S., and are representative examples of western, pop, jazz, and folk-music. While there are a few examples of non-Western types of songs, these songs are fairly traditional within music therapy practice in the U.S. and have been adopted as non-Western standards within American culture. International and Non-Western users may have to extrapolate a repertoire that is appropriate for the context and culture of their clients.

Of particular note is Chapter 7, which has a focus on the *ethics of self-awareness.* Meashey identifies that "we want to be taken seriously, and we also have a responsibility to approach each session with serious focus, to respect the tenderness of the relationship, and to value the trust our clients have placed in us to keep them safe" (p. 66). In line with ethical thinking, she emphasises that clinicians should seek guidance from professionals by doing our own personal work in therapy, by getting supervision when we are challenged, by finding a vocal teacher to continue our development, and by committing to self-care.

While not part of the ethics chapter, Meashey begins the journey into clinical session planning and therapeutic decision making with a discussion on the importance of "establishing and maintaining safety […] for every single session" (p. 81). She concludes the chapter by assuring music therapists that wherever they are in their development as a singer, there are an abundance of opportunities to learn, grow, and create. Meashey shares from her experiences as a professional jazz singer by outlining a levels system that is analogous to studying jazz. These levels can help music therapists conceptualise where they are in relation to their comfort level with singing and their own development as singers. Meashey acknowledges that music therapists will be in very different places with their vocal skills and should work within that skill set to the best of their abilities. Perhaps a music therapist is most comfortable with Level 1: "imitating and reproducing the exact method as written" (p. 87), or perhaps they are ready for Level 4: "getting an idea from reading the method and creating a brand-new method" (p. 87).

Chapters 11 through 20 highlight the use of voice across a variety of orientations to practice, from a cognitive behavioural framework to more depth-focused approaches such as psychotherapy and mandala work. There does not appear to be a hierarchy of approaches nor methods, nor one way of thinking that is favoured over any other type of thinking. Meashey provides clinical examples, vocal exercises, and experiences that address all domains of functioning including physical, cognitive, social, self-expression, and communication. Across the entirety of the text there is an impressive amount of differentiated vocal experiences offering numerous options for music therapy practitioners, and never once does it appear that she is outside of the bounds of her expertise.

Within the past six-months the COVID-19 crisis has had a significant impact on the way that music therapy services are delivered. Singers have had much attention directed toward them due to the possibility of spreading the virus while singing. The relatively limited science behind singing during COVID suggests that singing disburses droplets that can contain the virus and therefore singing with others presents a greater risk than speaking (Lund University, 2020). Over the past six-months I have sung less than I have across my entire lifespan. When I sing it is under a cloth mask, with an intimidating plastic face shield. My singing voice is now pressed and compressed, and there is no resonance. I find that my singing is muffled, and I feel like I am yelling all of the time. The way I teach my classes and interact with clients has changed and I am left with a deep and painful sadness as a result of this new reality. Meashey's book, even though written pre-pandemic, is like a soothing balm during this very difficult time. Her practical applications for singing that include humming and noticing physical sensations that occur (p. 3), to the use of songs to address emotional pain, anxiety, depression, and grief (p. 148) seem even more relevant as music therapists are relearning how to do the job of providing therapy both in person and virtually via telehealth. Meashey writes "songs as containers for emotion are quite versatile in their ability to hold a plethora of subtle and complicated textures, which can stay constant or shift like the tide" (p. 148). Whether standing on the shore or in the shifting tide, singing is both necessary for our clients and for us as music therapists and this message is clearly and passionately articulated by the author.

REFERENCES

Lund University. (2020). Could singing spread COVID-19? *ScienceDaily*. www.sciencedaily.com/releases/2020/09/200908101621.htm

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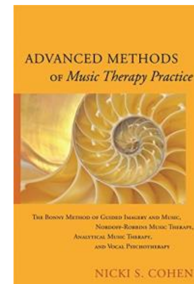
APPROACHES

BOOK REVIEW

Advanced methods of music therapy practice: Analytical music therapy, the Bonny method of Guided Imagery and Music, Nordoff-Robbins music therapy and Vocal Psychotherapy (Cohen)



Reviewed by Claudia Zanini
Universidade Federal de Goiás (UFG), Brazil

Title: Advanced methods of music therapy practice: Analytical music therapy, the Bonny method of Guided Imagery and Music, Nordoff-Robbins music therapy and Vocal Psychotherapy **Author:** Nicki Cohen **Publication year:** 2018 **Publisher:** Jessica Kingsley Publishers **Pages:** 248 **ISBN:** 978-1-84905-776-9

REVIEWER BIOGRAPHY
Claudia Zanini is a music therapist with Ph.D. in Health Science, Master in Music, Specialist in Music Therapy in Mental Health and Special Education, and Bachelor in Piano at UFG. She was the visitor researcher at Music Therapy Graduate Program of the Temple University (Fall/2018) and is a professor, vice-coordinator, and researcher of the Undergraduate in Music Therapy at UFG., as well as the president of the Department of Gerontology of Goiás Section of the Brazilian Society of Geriatrics and Gerontology (2014/18). She was the Chair (2014/17) and a member (2017/20) of the Research and Ethics Commission of the World Federation of Music Therapy (WFMT). She is currently a member of the WFMT Education and Certification Commission, a member of the Ethics Council of the Brazilian Union of the Music Therapy Associations, and is a music therapist at the League of Hypertension at Hospital das Clínicas/UFG. [claudiazanini@ufg.br]

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As a music therapy professor, I have had contact with different methods or approaches through lectures or brief workshops, as I always believed that it is important to have and pass on information to students about the existence of different theoretical paths and possible training for the professional. However, it is known that the main training in methods, approaches or models in music therapy are not available in all regions of the world and, for the most part, they are carried out in the English language.

The book *Advanced Methods of Music Therapy Practice*, from music therapist Nicki S. Cohen, can assist in widening the potential for music therapists to become aware of alternative methods and models. It explores the author's current view of some of the recognised methods applied in music therapy clinical practice.

In the preface, the author's narrative draws attention to her own life, which has always been centred on music. Her training in the Bonny method of Guided Imagery and Music (GIM) led her to consider herself a "better teacher, therapist, citizen and person" (p.13). The motivation to write the

book was to answer why, for the author, it was necessary to go deeper into music therapy by doing advanced training in one of the methods to understand the full potential of the profession. To answer this question, she chose four of what she considers to be the main methods: Analytical Music Therapy (AMT), the Bonny method of GIM, the Nordoff-Robbins Music Therapy (NR-MT) and Vocal Psychotherapy (VP). She states that they were methods "whose practices are comprehensive and psychodynamic in nature [...] In most cases these methods are taught outside of the general parameters of any Music Therapy Academic degree requirements" (p. 14). I am aware, though, that in some countries the Nordoff-Robbins method is not considered advanced and is core to the teaching of our profession. This was not considered by the author, which is somewhat surprising.

An exclusive component of the book is giving voice to renowned professionals involved in these methods by having them answer a series of questions. Some challenges are pointed out by the author, such as the choice of the interviewed music therapists; the definition of the term method, used since as the title of this work; and the differences between American and British English because the author "discovered a major discrepancy between the two countries regarding the usage and perception of the terms advanced, post-graduate and method" (p.15).

In the opening section, one of the author's conclusions is that, with the advances of the profession in the United States, new perspectives in research, new clientele and governmental changes will make it impossible in the future to practice music therapy without having a Master's degree. This already happens with other healthcare professions and is also the case in some countries currently. The author points out that, although the United States and the United Kingdom are pioneers in the insertion of music therapy in training programs and as professional practices, there are different terms used, levels of academic training, different overall standards and different ways to standardise music therapy practice.

Early on in the text, Cohen justifies the use of the term "method" for the topic of advanced music therapy practice in the context of the first quarter of the 21st century. It presents a reflection on the terms "theory," "model" and "method" in music therapy, bringing theorists from the field such as Even Ruud, Kenneth Bruscia, Leslie Bunt, Brynjulf Stige, Thayer Gaston and Kenneth Aigen, among others. She comments that a music therapist who chooses to train in an advanced method of music therapy tends to make this decision after years as a clinician.

Thus, the choice of the four aforementioned methods was because they were created by music therapists, in addition to fulfilling strict criteria:

> 1) Master's degree, or training occurring concurrently with Master's degree candidacy; 2) specified years of clinical experience prior to beginning the training; and 3) a time-intensive process that includes multiple workshops, clinical hours, supervised sessions, self-growth requirements, personal sessions, reading assignments, and final projects to complete the training and to receive the corresponding clinical designation (p. 69).

To explore these, the author states that she used techniques related to transcendental realism, covering questions about insertion, historical development, current formation, practice and the existing literature on each of the methods. Thus, section 2 is subdivided into chapters dedicated to

explaining the chosen methods and presenting their creators. To write the chapter on AMT, Cohen spoke with Mary Priestley's son, John Priestley, as his mother, at the time, was already ninety years old and very ill.

The author explains some techniques developed by Mary Priestley, commenting that "with its strong theoretical foundations are the indigenous AMT techniques so skilfully developed by Mary and her colleagues" (p.85). These techniques can be organised into the following categories: consciousness probing, accessing the unconscious and ego strengthening. In addition, in this chapter, the main techniques, the description of an observed AMT session, the training and the list of some writings are presented. A search undertaken by the author for AMT resources revealed that most of these writings are authored by Benedikte Scheiby. Regarding the future, AMT points to a discrete therapeutic approach because of the "current lack of available trainers" (p. 93). However, she recognises that the techniques and elements of the method have been incorporated in different universities and countries and new client groups have been treated by music therapists trained in the method.

When writing about GIM, the author reports that this was "a labor of love" (p.95) for her because Helen was her teacher, mentor and friend until her death in 2010. She presents Helen's story and how she came to create the GIM Method. It is curious to say that, in the 1970s, many members of the National Association for Music Therapy (NAMT) criticised Bonny's work, for relating music therapy to spirituality, an aspect so recognised and linked to the method later on. The author believes that the new generation of professionals in the American and European Associations (AMI – Association for Music and Imagery, and EAMI – European Association for Music and Imagery) will help to form new generations of Bonny method practitioners.

A later chapter focuses on NR-MT, starting from the lives of its founders, Paul Nordoff and Clive Robbins, who preferred to call their creation an "approach". The author recalls a remarkable moment in her life when she watched the 1976 film *The Music Child.* For this book, three renowned music therapists linked to this method were interviewed: Alan Turry, Kenneth Aigen and Gary Ansdell. For Cohen, NR-MT is clearly the advanced method that requires the highest level of musical skills from music therapists.

Then, in chapter 7, the author presents the method of VP, drawn from an interview with the creator Diane Austin. The techniques were created "over time and are aligned with different theoretical constructs that Diane studied in the 1980s and 1990s" (p. 149). Music has always been the centre of Austin's life, who also studied theatre. In collaboration with music therapist Barbara Hesser, Diane established training in VP at New York University (NYU).

Based on the formation and trajectory of Diane Austin, the author presents the techniques of this eminently vocal method, which is analytically oriented. A video found by Cohen with a *"free associative singing session"* is commented upon. In addition to these topics, training in VP is presented, which uses breathwork, natural sounds, vocal improvisation, chants and songs: "Each training group is limited to eight students per year. It takes a student a minimum of two years to complete VP training" (p. 159). Finally, the chapter presents the texts published by Diane Austin and other professionals.

Section 3 includes the analyses of interviews held with music therapists discussing these methods. It is interesting to note that the only founder of these methods among the interviewees was music therapist Diane Austin. The respondents observed how the four methods had taught them about

depth. Regarding the changes in the relationship between the interviewees and the method over the years, Cohen says: "some of the major themes I discerned were personal reconstruction, relationships with music, amendments, roots, and new populations" (p. 175). The final chapter makes a relevant contribution to the book, as it analyses the last two questions asked to professionals, which are related to the future of advanced methods and the music therapist profession itself. The first, considered by Cohen as the most potent question, was about the method being part of the practice of music therapy. All respondents believe that the methods covered in the book are part of the practice of music therapy. The biggest barrier to their greater use is that, for the most part, they are taught outside universities and, usually, training takes place after academic training. For the author, there is no forecast for these methods to be included inside universities "as they don't seem to fit the purview of most academic programs" (p. 191). Another point cited is that few experts are trained in more than one method.

Regarding the questions about the future, some experts are concerned with the continuity of the method after their deaths, but others are confident that the method will survive. This may include conducting research and training that uses the methods to connect with students from around the world.

As a final note, the book has interesting appendices that contribute to readers' knowledge since it describes a list of publications regarding the three of the cited advanced methods, with authorship of their creators and of other professionals.

Finally, Cohen's book takes us through the past, present and future of music therapy, allowing the reader, in addition to knowing the advanced methods presented, to reflect on their life experiences and their own trajectory as a music therapist. What will be the next step? A careful reading of *Advanced Methods of Music Therapy Practice* can bring inspiration.

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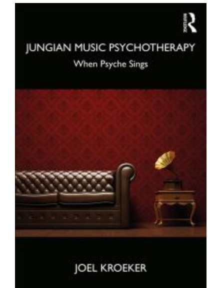
BOOK REVIEW



Jungian music psychotherapy: When psyche sings (Kroeker)

Reviewed by Catherine O'Leary
Independent scholar, UK

Title: Jungian music psychotherapy. When psyche sings. **Author:** Joel Kroeker **Publication year:** 2019 **Publisher:** Routledge
Pages: 187 **ISBN:** 978-1-138-62566-2

REVIEWER BIOGRAPHY
Catherin O'Leary BA, BMus, MA, is a registered music therapist and an EAMI registered GIM therapist. She has worked in the US, the UK and Ireland with a variety of populations. She has an MA in Jungian and Post- Jungian Psychology from Essex University. Her dissertation was on Jung and Music. [c-oleary@hotmail.co.uk]

Publication history:
Submitted 7 Jan 2021
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First published 17 Feb 2021

Joel Kroeker's book *Jungian Music Psychotherapy: When Psyche Sings* is a wonderful addition to the growing body of literature on Jungian psychology and music. The book explores the musical environment or eco-system, which includes every kind of interaction we have with music, whether it be listening, playing, composing, imagining, our conscious awareness of the music in and of our lives and what may lie beyond our conscious awareness. One of Kroeker's aims with this book is to address the gap in the Jungian literature where music is the most unexplored of all the arts.

Kroeker makes a connection between music and dreaming. Music brings you into the imaginal realm very quickly. This allows it to be full of potential for further amplification but also poses some risks. In order to fully explore what happens when we "are inside the musical ecosystem" (p.34), the author feels a new form of depth psychology is needed. The approach he has developed, and which is described in detail in the book, is what he calls *Archetypal Music Psychotherapy* (AMP).

The book is laid out in 14 chapters, many of them quite short, with a foreword by Jungian analytical psychologist, Mark Winborn, and an additional introduction by Kroeker. Each chapter is referenced separately and there is an excellent index at the back. The book is a treasure trove for anyone working with music who is interested in a Jungian approach but it is also aimed specifically at analysts themselves. Some of the chapter titles will draw a smile of recognition such as *The Red Album*.

From the early years of the twentieth century, analysts and analytical psychologists have been suggesting that music itself has much to offer in analysis. Hildemarie Streich, an early protégée of Jung's, recommended paying attention to "the least occurrence of a musical motif. While it may appear entirely insignificant, its analysis yields much more than it was first assumed" (Streich, 2009, p. 65). The psychoanalyst Theodore Reik also believed that the incidental music accompanying our conscious thinking was never accidental and that we would benefit psychologically from paying

attention to it. "We all put much of our hidden thoughts and preconscious emotions into the melodies we hear, and we all would be surprised if we paid more attention to them when they echo in us " (Reik 1953, p.102). Jung himself suggested that music should be part of every session (Tilly, 1977). As a music therapist I was trained to listen to every aspect of the session, to hear how the patient or client 'sounds', whether that is what they are playing or the rhythm and tempo of their movement, of how they are feeling and relating. Kroeker is also encouraging analysts to pay attention not only to every musical meme, but to bring a musical ear to the session and to listen to the dialogue as if it were a piece of music.

There are two questions he returns to over and over in the book: what is music and what is perception? Music is multi layered and perception is creative. Music is like a waking dream, carrying a tremendous amount of content, both conscious and unconscious. Jungian analysis is all about extending our awareness beyond our everyday ego consciousness. Both music and dreaming open us beyond our conscious ego stance. Properly facilitated expressive musical processes offer an outlet for untapped inner resources and can reveal significant aspects that may not arise through verbal work alone. To assume that music "is loaded with meaning" and "to experience music like this is to begin a dialogue with deep psyche" (p. 43).

Regarding perception, Kroeker discusses the difference between hearing and listening. He speaks of our auditory digestive system which metabolises the sounds we hear into meaning, similar to our self-regulating psyche. We hear but there is a lot more going on and we can open ourselves up to it. While the ear hears, something much deeper within us listens and creates meaning. Listening is a creative experience. We create music out of sound. This latter point is like a leitmotif in the book. Music as such does not exist. Kroeker's formula is that "'music = sound + time and any further interpretation is related to cultural or personal associations" (p. 137). The transformation of turning perceived sound into music remains an inexplicable enigma (p. 38). Our music ego hears more than our everyday ego. By tuning in we can hear more of our music, learn to listen through the surface layers and become aware of our 'deaf spots' (p. 44). "The psychic reality is that music, like a dream, is often merely a trigger for our own experience of our inner world" (p. 42).

After more than 20 years working creatively with patients, Kroeker has observed certain patterns with enough consistency to form AMP. He states that "AMP is not a formulaic method" (p. 71) nor is this a workbook, but that it is "more like a view, which this book exposes the reader to by circumambulating various ways of relating to musical symbols" (p. 71). Chapter 8 describes the six principles that he feels are core to this view: 1) Perception is a creative act; 2) Loosening attachment to mastery can liberate expression; 3) Improvisation is the inner state manifested in outer form; 4) Sound is an image, which can be a glimpse of wholeness; 5) Active imagination can be done through musical means; 6) Holding irrelevant aspects in a constellation can lead to consilience. Each principle is discussed separately. A number of these principles are very familiar territory for music therapists but Kroeker works consistently from a Jungian perspective and maintains a symbolic attitude.

If some of the ideas are familiar, what is different in this book is the language Kroeker has developed to talk about music in analysis. As music therapy developed as a profession in the second half of the twentieth century a recurring debate concerned the verbal content of music therapy sessions. How much, if any, verbal content should there be and what psychological model should inform that content? The challenge is always how to find a vocabulary that can translate musical

experience into words. Music therapist and Jungian analyst, Diane Austin, described how as she became more skilled in making verbal interventions in her sessions, she found that she was losing the music (Austin, 1999). She had to work at integrating music once again with the words in her analytically oriented music therapy. Kroeker has succeeded in devising a vocabulary combining musical and psychological terms and has introduced a number of very useful concepts in this book, certainly some that I will continue to use. The following are but a few examples that I particularly enjoyed: diatonic fantasy refers to "the pre-initiatory childhood notion that the whole world will be harmonious for us" (p. 109); musical foreclosure refers to the danger of shutting down a musical dialogue prematurely and includes "offering too many musical ideas too soon in an analytical improvisation session, being overly musically supportive when confrontation or silence is more appropriate, playing to the genre rather than responding in a more nuanced way " (p. 117). Personally, I am always aware of the attraction of a final cadence in improvisation! He talks of splitting sound into good and bad, exploring pain through the dissonance -consonance threshold and musical tide-pooling. These are new terms to describe well recognised experiences and a wonderful addition to the literature.

While it has been difficult for music therapists to integrate the verbal side, Kroeker recognises that bringing the music in is not easy for many analysts. He wonders why analysts assume authority with verbal communication but presume that musical interaction is only for musical experts. He echoes Small's idea that we must reclaim music and 'musicking' as an expression of our humanness (Small, 1998). Too often we hand music over to experts, composers, performers, academicians, those who we think know about music. 'To music' includes every kind of interaction we have with music, whether it be listening, playing, composing, imagining, our conscious awareness of the music in and of our lives and what may lie beyond our conscious awareness. However, he also warns a number of times that music brings you into the imaginal realm very quickly and there is a danger of going too deep too fast. As a music therapist I have spent many hours improvising and developing my inner ear. Analysts also need to practice "reflective improvisation, depth-oriented composition and contemplative listening" (p. 146). Music mastery as such is not required.

Musical Approaches to Analytic Technique', Chapter 12, is the longest chapter in the book. In this chapter Kroeker's discussions include the similarity between musical and analytic structure, musical transference, musical acting out and the many defences that can be just as easily expressed musically. No one has given such a deep and thorough exploration of what music has to offer analysis.

Kroeker is hoping that this book will spark music-oriented applications for analysts and analysands. I hope so too. He has shown what a fruitful collaboration it is, and I look forward to further developments.

REFERENCES

Austin, D. (1999). Vocal improvisation in analytically oriented therapy with adults. In T. Wigram & J. de Backer (Eds.), *Clinical adaptations of music therapy in psychiatry* (pp.141-157). Jessica Kingsley Publishers.

Reik, T. (1953). *The haunting melody: Psychoanalytic experiences in life and music*. Farrar, Straus and Young.

Small, C. (1998) *Musicking.* Wesleyan University Press.

Streich, H. (2009). Music in dreams. *Jung Journal: Culture & Psyche, 3*(2), 63-73. https://doi.org/10.1525/jung.2009.3.2.63

Tilly, M. (1977). The therapy of music. In W. McGuire & R.F.C. Hull (Eds.), *C.G. Jung speaking: Interviews and encounters* (pp. 261-263). Picador Publishers.

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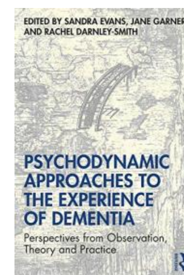
BOOK REVIEW

Psychodynamic approaches to the experience of dementia: Perspectives from observation, theory and practice (Evans, Garner & Darnley-Smith, Eds.)



Reviewed by Jodie Bloska
Cambridge Institute for Music Therapy Research, Anglia Ruskin University, UK

Title: Psychodynamic approaches to the experience of dementia: Perspectives from observation, theory and practice **Editors:** Sandra Evans, Jane Garner & Rachel Darnley-Smith **Publication year:** 2019 **Publisher:** Routledge **Pages:** 268 **ISBN:** 0415786657

REVIEWER BIOGRAPHY
Jodie Bloska is a music therapist and clinical research fellow at the Cambridge Institute for Music Therapy Research, where she is also pursuing her PhD. She studied music cognition and psychology at McMaster University, before completing her MA in music therapy at Anglia Ruskin University in 2015. Since qualifying, she has worked primarily with people living with dementia and with adults in neurorehabilitation. She is also currently working on the international research study 'Homeside', which is exploring music interventions for people with dementia and their caregivers. [Jodie.bloska@anglia.ac.uk]

Publication history:
Submitted 29 Jun 2020
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First published 16 Sept 2020

Psychodynamic Approaches to the Experience of Dementia is a compendium of 18 chapters by a multi-disciplinary group of editors and authors with extensive experience working in dementia care. The authors include professionals from psychiatry, psychology, music therapy, art therapy, social work, and geriatric medicine, primarily based in the UK. The book argues the importance of a psychosocial understanding of dementia, not only for people with a diagnosis, but also for friends, families, and caregivers. Kitwood's (1997) person-centred approach underpins the chapters, highlighting the importance of understanding an individual's physical and emotional responses to this disease. The authors reflect on their experiences of working with people living with dementia, caregivers and other clinicians; they emphasise how psychodynamic theories have been helpful for them in understanding the people they work with. A number of themes arise throughout the book, such as challenging assumptions about dementia, the importance of relationships and an emphasis on support for caregivers.

A salient aspect of this book is that it challenges society's assumptions about dementia. Resnick (Chapter 1) presents a thoughtful exploration of our unconscious responses to dementia and stresses the importance of recognising negative responses in order to confront and alter them. He and Garner (Chapter 18) specifically refer to Kitwood's (1997) term 'Malignant Social Psychology', which describes how responses to individuals living with dementia can be detrimental to their wellbeing due to, for example, stigma, infantilising and disempowerment. Garner (Chapter 2) and Brown (Chapter 4) discuss the impact of ageism, both on an individual level and in government policies, in a society where "value

is determined by productivity" (Brown, p. 49). This perspective can impact how a person living with dementia views themselves, and also how they are treated by those around them. In Chapter 3 (Segal), Chapter 7 (Jeyasingam) and Chapter 9 (Evans), the authors discuss and challenge the traditional assumption that therapy is not beneficial or ethical for people with cognitive impairments. These authors raise the question: does a cognitive impairment minimise one's ability to engage in the therapeutic process? They argue that people with dementia, who will be facing various losses as well as end of life, should have access to therapy to provide appropriate support throughout their diagnosis.

Many of the authors stress the importance of relationships for people affected by dementia, including maintenance of previous relationships and the development of new ones. This is particularly relevant to psychodynamic therapy, which is focused on the therapeutic relationship and can aim to reduce emotional isolation. Evans (Chapter 9) and Balfour (Chapter 10) both discuss attachment (Bowlby, 1969; Kitwood, 1997) and how this can impact on the experience of psychological symptoms, such as depression and anxiety, for both people with dementia and their caregivers. Garner (Chapter 2; Chapter 18), Hagger (Chapter 6) and Balfour (Chapter 10) highlight how relationships provide containment (Bion, 1962, 1970), which Garner describes as how others can "give meaning and understanding and to help the [person with dementia] make sense of the current moment" (p. 237). Of course, this also aligns with Kitwood's (1997) focus on personhood, as Garner (Chapter 16) states: "personhood will be held within life history and experiences, in relationships and in engagement with others" (p.201).

There is also a focus throughout on caregivers, whether paid or unpaid. Chapter 5 (Evans) is dedicated to thinking about 'caring for the carer' whilst Hagger (Chapter 6) looks at how working with individuals who have dementia may be quite difficult, as "staff may identify with and experience similar painful feelings to those that the patient is having of hostility, helplessness and frustration" (p. 72) due to the progression of the disease. The authors call for all caregivers to have better working conditions and recognition, with access to support, supervision and therapy to help with the emotional demands of caregiving. This is reflected in a shift in current research and practice to include the caregiver in interventions developed for dementia; an example of this is the international Homeside study, which is exploring music and reading for people with dementia and their caregivers (Baker et al., 2019).

It is worth noting that throughout the book the authors highlight the importance of the arts in dementia for maintaining emotional contact (Evans, Chapter 15) and relationships (Garner, Chapter 18). The book has an emphasis on the role of the arts therapies, with one of the editors, Rachel Darnley-Smith, being a music therapist and lecturer in music therapy. There are two chapters dedicated to music therapy (Darnley-Smith, Chapter 12; Freeman, Chapter 17) and one about art therapy (Byers, Chapter 8). Darnley-Smith explores Winnicott's (1971) theory of 'mirroring', where music-making can provide "the experience of being seen and heard" (p.153). Freeman discusses her work within end-of-life care in an NHS setting, and how music therapy can provide companionship and relaxation for those in the later stages of dementia. In a case study, Byers quotes a participant, who says art therapy is about "making time to 'create', to 'create' being better than to 'destroy'" (p.99), which suggests a focus on abilities rather than losses, when engaging in the arts. These chapters offer insight into how music and art therapy can be important for attachment, containment and self-identity for people living with dementia. In general, the arts can provide an avenue for participating in new things, for creativity and for being together with others.

Overall, *Psychodynamic Approaches to the Experience of Dementia* provides a strong argument for the value of a psychodynamic perspective for those affected by dementia. This book challenges assumptions regarding who can benefit from a psychodynamic approach and encourages clinicians to always consider the emotional impacts of the disease, not only the person with dementia but for those around the person, including themselves. Whilst the book presents useful perspectives from clinicians, the absence of voices of people with lived experience does stand out, especially considering recent calls for patient and participant involvement in the development of services. However, I would recommend this book as it provides a useful way of understanding personal, professional, and societal responses to dementia.

REFERENCES

Baker, F. A., Bloska, J., Braat, S., Bukowska, A., Clark, I., Hsu, M. H., Kvamme, T., Lautenschlager, N., Lee, Y.-E. C., Smrokowska-Reichmann, A., Sousa, T. V., Stensaeth, K. A., Tamplin, J., Wosch, T., & Odell-Miller, H. (2019). HOMESIDE: Home-based family caregiver-delivered music and reading interventions for people living with dementia: Protocol of a randomised controlled trial. *BMJ Open, 9*(11), e031332. http://dx.doi.org/10.1136/bmjopen-2019-031332

Bowlby, J. (1969). *Attachment and loss, vol. 1.* Hogarth Press.

Bion, W. R. (1962). *Learning from experience.* Heinemann.

Bion, W. R. (1970). *Attention and interpretation.* Tavistock Publications.

Evans, S., Garner, J. & Darnley-Smith, R. (Eds.). (2019). *Psychodynamic approaches to the experience of dementia: Perspectives from observation, theory and practice.* Routledge.

Kitwood, T. (1997). *Dementia reconsidered: The person comes first.* Open University Press.

Winnicott, D. W. (1971). *Playing and reality.* Pelican Books.

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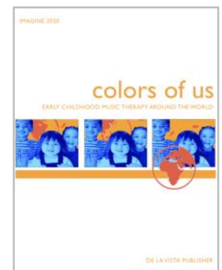
BOOK REVIEW

Colors of us: Early childhood music therapy around the world (Kern, Ed.)



Reviewed by Ilene Berger Morris
Alternatives for Children, USA

Title: Colors of us: Early childhood music therapy around the world **Editor:** Petra Kern **Publication year:** 2020 **Publisher:** De La Vista Publisher **Pages:** 373 **ISBN:** 2153-7879

REVIEWER BIOGRAPHY
Ilene "Lee" Berger Morris is a board-certified music therapist, a New York State Licensed Creative Arts Therapist, and a Fellow of the Academy of Neurologic Music Therapists. Lee holds a master's degree in Neurologic Music Therapy, a subspecialty of music therapy based on a neuroscience model of music perception/production. A professional music therapist for close to 4 decades, Lee has worked extensively with young children with developmental challenges as well as patients of all ages undergoing neurologic rehabilitation. Lee has performed research and authored articles on applications of music therapy in people with autism, with hemiplegia, and with Parkinson's disease. [lee.morris@alternativesforchildren.org]

Publication history:
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Music therapists seeking a comprehensive resource on working in early childhood have recently hit the jackpot. The 2020 edition of *Imagine Magazine*, an annual online magazine dedicated to early childhood music therapy, has taken the form of an interactive compendium of international music therapy practice with young children. In *Colors of Us: Early Childhood Music Therapy Around the World*, editor Petra Kern has assembled material shared by more than 80 leaders in the field, analysing the way the music therapy process with this age group is funded, delivered, and evaluated internationally. Available as an e-book, *Colors of Us* is a multi-media collection of interviews, podcasts, videos, graphics and text, which focus on cultural responsiveness, diverse language learners, trauma-informed care for displaced children, and the unique aspects and convergences of music therapy practice all over the globe.

Over the past several decades, diversity and multicultural topics have appeared with greater frequency in music therapy publications, drawing attention to the need for music therapists to increase their awareness of these matters and gain competence in related skills (Kim & Whitehead-Pleaux, 2015). Although the movement to make cultural issues a central part of training and practice has been gaining momentum, there is a dearth of specific strategies outlined for reaching that goal (Hadley & Norris, 2016). *Colors of Us* can help to fill the void.

The book is divided into four distinct parts, bringing the overarching theme to the reader through different approaches and tools. The first major chapter consists of three in-depth interviews, presented through text, photographs, and video excerpts, that prepare the reader for cultural considerations in music therapy. In addition to defining the term 'cultural responsiveness', Dana Bolton describes ways

to interact cross-culturally with children and families through choice of music, language, communication style, awareness of customs and observances, and humour. Serra Acar focuses on diverse language learners and how linguistically and culturally responsive approaches, which support language and literacy development in both languages, promote the child's overall growth. Emma Martin and Olivia Yinger cover the effects of trauma on young displaced children, explaining neurological, psychological, and physiological standpoints and emphasising the importance of trauma-informed care.

Colors of Us widens its scope in the second chapter in which 11 music therapists, including this reviewer, share their expertise in various subjects related to the theme, such as working with children in special education, foster care, a neonatal intensive care unit, a refugee camp, an orphanage, and a museum. Links in the book take the reader to podcasts of these practitioners and educators providing their perspectives on cultural responsiveness, diverse language learning, and trauma-informed care, in their own voices. Unfortunately, there are no transcripts of the podcast recordings included with the book download, which would have enabled searching for specific terms and information contained within.

In chapter three, *Colors of Us* takes us on a tour of the world through country reports. Data from 41 countries has been compiled, providing access to country-specific information such as demographics, laws and policies, resources, and music playlists – all available with a virtual flip of the page. The therapeutic process is sketched out, from referral to termination. Presented from the vantage points of music therapists working in each region, *Colors of Us* enables the reader to compare the way music therapy for young children is practiced globally. Jacinta Calabro, a music therapist from Melbourne (Australia) noted that "it's fascinating to see how early childhood music therapy is practiced around the world' and pointed out how the book highlights 'our need to invest in cultural responsiveness training and approaches" (Personal communication, 21st August 2020). The represented clinicians also share their visions for the future of music therapy in their countries through video snippets or text. Brief biographies about these music therapists conclude each country report.

Chapter three is the one-stop information shop of the book. A tremendous amount of information can be gleaned with a glance at the infographics on the country report pages. Whereas one may gravitate to the other parts of the book to be inspired by the stories and expertise of the featured music therapists, this section allows the reader to drop in and gather facts and figures, including the prevailing view of disability in each region. Within each country report, a clinical example takes the form of either a chart outlining a sample music therapy session, a video case vignette, a description of session structures, a listing of therapeutic materials, a statement of purpose, or other detailed information. Comparisons and contrasts in music therapy practice emerge from these pages. For instance, it is clear that there is significant disparity in the recognition, support, and funding of music therapy in different parts of the world.

A highlight of the country reports chapter is the playlist of children's music for each country, classified by the categories of traditional and contemporary songs. This reviewer joins the ranks of music therapy professionals and students who have clamoured for a source of this kind of knowledge, a go-to introduction to the kinds of music that may be familiar and meaningful to young clients from these countries. Ashley Jutte, a music therapy student at Ohio University (USA) reported that the lists 'sparked my excitement to continue developing and expanding my repertoire, which is really

encouraging to me!' (Personal communication, 18th August 2020). Links play renditions of the alphabet song from various countries, driving home the observation that, in music and other things, our similarities outweigh our differences, and our differences make life more interesting.

Colors of Us concludes with a Resources section curated by consultant Camille Catlett that homes in on issues of culturally responsive practice, dual language learners, building resistance for trauma victims, promoting equity in our practices, and supporting children in immigrant families. Gems of information are awaiting discovery within this collection via links to guides, lists, articles, and reports as well as a toolkit of resources categorised and annotated by the author to facilitate access and exploration. Though this chapter of the book takes up relatively few virtual pages, the material it represents is immense. For instance, if in need of a race-informed children's book to incorporate into a music therapy session, you might click on the link for 'Culture, Diversity, and Equity Resources'. That brings you to 25 options of handouts - perhaps you'll choose 'Race-racism resources.' Click on that and find 15 possibilities to further direct your search. Pick 'Talking to children about race and racism', then find 'Children's books that address race, racism, and diversity'. Now peruse 13 titles, book covers, and descriptions – I would recommend 'All are welcome here' (Penfold, 2018) for its beautiful illustrations and its rhyming stanzas that easily lend themselves to a musical presentation. Along the way, you will have scrolled past a plethora of interesting articles and materials to return to and dig into later. Many of the topics and webpages linked to this chapter are cross referenced and available through other paths.

Jessica Heinz, a music therapist based in Louisville, Kentucky (USA) described the effect that *Colors of Us* had on her with this thought "it is as though Dr Kern could see the future and knew exactly what the music therapy world needed to expand its toolbox and extend our cultural worldview past our own backyards" (Personal communication, 17th August 2020). *Colors of Us* is a recommended resource for international music therapy practice focusing on early childhood, remarkable not only for meeting its ambitious mark but for doing so with most of its production occurring during a global pandemic. This is a book that you could consult on an as-needed basis, but please give yourself the gift of reading it in its entirety, sitting with it for a while, and uncovering the many ways to delve into and radiate from its core chapters.

REFERENCES

Hadley, S., & Norris, M. (2016). Musical multicultural competency in music therapy: The first step. *Music Therapy Perspectives, 34*(2), 129-137. https://doi.org/10.1093/mtp/miv045

Kern, P. (Ed.) (2020). *Colors of us: Early childhood music therapy around the world*. De La Vista Publisher.

Kim, S.A. & Whitehead-Pleaux, A. (2015). Music therapy and cultural diversity. In B. L. Wheeler (Ed.), *Music therapy handbook* (pp. 51–63). The Guilford Press.

Penfold, A. (2018). *All are welcome.* Alfred A. Knopf.

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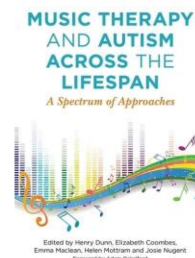
BOOK REVIEW

Music therapy and autism across the lifespan (Dunn, Coombes, MacLean, Mottram & Nugent, Eds.)



Reviewed by Thomas Bergmann
Ev. Krankenhaus Königin Elisabeth Herzberge, Germany

Title: Music therapy and autism across the lifespan **Editors:** Henry Dunn, Elizabeth Coombes, Emma MacLean, Helen Mottram & Josie Nugent **Publication year:** 2019 **Publisher:** Jessica Kingsley Publishers **Pages:** 398 **ISBN:** 978-1-78592-311-1

REVIEWER BIOGRAPHY
Thomas Bergmann, certified music therapist, PhD in psychology. Head of the therapy department of Berlin Treatment Centre for Mental Health in Developmental Disabilities, lecturer, and supervisor. Research in autism spectrum conditions, music and art-based interventions, emotional development, assessment, and diagnostics. [bergmann.t@t-online.de]

Publication history:
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The authors of *Music Therapy and Autism across the Lifespan* rely primarily on case studies to illustrate music therapy with people on the autism spectrum. This edited book centres on practice in various settings within the UK, reflected in 13 chapters and presented in three major sections: (1) improvisational approaches, (2) collaborative approaches, and (3) music therapy approaches associated with autistic identity and culture.

The book opens the door to music therapy practice with individuals who are on the autism spectrum. This is done narratively with numerous case studies, both one-to-one and group settings, reflecting each therapist's approach. These range from a psychoanalytically informed approach to collaborative methods and approaches focusing on neurodiversity and self-esteem. The book's clear structure, postlude included, greatly assist with navigating through this array and in finding specific information and inspiration when used as a reference. However, looking at the UK from an outside perspective, a psychoanalytic orientation seems surprising due to the fact that autism spectrum condition (ASC) is rooted in multiple genetic and environmental factors (Grabrucker, 2012; Rylaarsdam & Guemez-Gamboa, 2019). Historically speaking, many diagnosed children, together with their families, suffered from psychodynamic interpretations of ASC as being caused by a lack of maternal warmth connected with the demand to take the children away from their families (Kanner, 1973). This dilemma may have been initially revealed by way of developmental theories from authors with a psychoanalytic background. These include Daniel Stern (2000), whose work plays a prominent role in many approaches found in this book. A second reason could be the strong psychoanalytic music therapy tradition in the UK represented, for example, by Mary Priestley (1994). Behavioural approaches are almost completely missing from this text next to functional approaches adopted from neurologic music therapy. The lack of these approaches conveys a non-medical, humanistic standpoint, including therapy goals beyond autistic symptomatology in contrast to social skills trainings solely focusing on

adaptive functioning. However, neurologic approaches based on auditory-motor mapping may be promising due to effects on motor control, selective attention, speech production, language processing and acquisition, and brain connectivity as recently discussed by Janzen and Thaut (2018). In these approaches motor dysfunctions are seen as ASC-core symptoms in line with current research (Fulceri et al., 2019) and music may play a key role in future treatment concepts.

A respectful and person-centred attitude is reflected throughout the entire book by, for example, avoiding the use of the term “disorder” when writing about autism, as in line with many self-advocates who claim that autism is not a disease and should be accepted instead of being cured (Shore, 2006). An honest desire to understand people with autism and their needs and to reflect one’s own relationship with these individuals is noticeable throughout the book, making it furthermore worth reading.

The individuals and groups described in manifold case studies represent a broad age span and diverse levels of functioning. This enriches the current music therapy literature, which focuses primarily on children who are on the spectrum. Since autism is a lifelong condition, many people on the spectrum are in need of ongoing support, especially in transitional situations. Thus, reports and studies on music therapy with adults are well received. Against this background, *Music Therapy and Autism across the Lifespan* may encourage therapists to offer their unique music-based interventions to adolescents on the cusp of adulthood, as well as to adults and even elders. Case studies presented in this book, however, involve adults with intellectual disability; high-functioning adults with ASC are not represented. This may reflect music therapy practice but does not serve to explain why this population is excluded. Due to the ability to conceal autism symptoms and cognitively compensate social interaction deficits, these people may somehow manage to function in our society but often for a high price, resulting in depression, anxiety and an increased suicide risk. Here, it seems as if dance movement therapists are better informed about this population by fostering body awareness, social skills, self–other distinction, and well-being using synchrony-based interventions as reported in controlled studies (Koch et al., 2015; Koehne et al., 2016). This indicates that music/movement interventions may be appropriate and helpful in achieving specific goals in adults with high-functioning autism.

Finally, this book may be seen in the light – or better in the shadow – of the TIME-A study (Bieleninik et al., 2017); a million-dollar international multi-centre randomised controlled trial (RCT) indicating that improvisational music therapy did not show significant improvements on social affect in young children with ASC. This RCT was a shock for the worldwide music therapy community, following decades of research and practice in the field of ASC with promising results and a wide spectrum of approaches. This is explicitly focused upon in the first chapter of *Music Therapy and Autism across the Lifespan*. From an evidence-based research perspective, this book can be seen as reverting to practice and narrative case reports concentrating on music therapy principles and restoring self-confidence. This step may be crucial in order to push ahead, re-examine, refine methods, further develop assessments, define treatment goals and targeted groups. On this solid foundation a new start may be made to initiate systematic controlled studies implementing established scales and follow-up measurement to indicate maintaining treatment effects even beyond the therapeutic context.

Pulling it all together, this book is strongly recommended for all music therapists working with people who are on the autism spectrum. In addition, professionals in the field, families, and even those on the spectrum may benefit from the revealing case studies, effectively depicting just what music

therapy is all about. The diverse approaches, illustrations and reflections highlight decades of experience in this field, colourfully portraying the potential of *music therapy and autism across the lifespan*.

REFERENCES

Bieleninik, L., Geretsegger, M., Mössler, K., Assmus, J., Thompson, G., Gattino, G., & Gold, C. (2017). Effects of improvisational music therapy vs enhanced standard care on symptom severity among children with autism spectrum disorder: The TIME-A randomized clinical trial. *JAMA*, *318*(6), 525–535. https://doi.org/10.1001/jama.2017.9478

Fulceri, F., Grossi, E., Contaldo, A., Narzisi, A., Apicella, F., Parrini, I., & Muratori, F. (2019). Motor skills as moderators of core symptoms in autism spectrum disorders: Preliminary data from an exploratory analysis with artificial neural networks. *Frontiers in Psychology*, *9*, 2683. https://doi.org/10.3389/fpsyg.2018.02683

Grabrucker, A. M. (2012). Environmental factors in autism. *Frontiers in Psychiatry*, *3*, 118. https://doi.org/10.3389/fpsyt.2012.00118

Janzen, T. B., & Thaut, M. H. (2018). Rethinking the role of music in the neurodevelopment of autism spectrum disorder. *Music & Science, 1*(1), 205920431876963. https://doi.org/10.1177/2059204318769639

Kanner, L. (1973). *Childhood psychosis: New studies and new insights.* V.H Winston & Sons.

Koch, S. C., Mehl, L., Sobanski, E., Sieber, M., & Fuchs, T. (2015). Fixing the mirrors: A feasibility study of the effects of dance movement therapy on young adults with autism spectrum: disorder. *Autism: The International Journal of Research and Practice, 19*, 338–350. https://doi.org/10.1177/1362361314522353

Koehne, S., Behrends, A., Fairhurst, M. T., & Dziobek, I. (2016). Fostering social cognition through an imitation- and synchronization-based dance/movement intervention in adults with autism spectrum disorder: A controlled proof-of-concept study. *Psychotherapy and Psychosomatics, 85*, 27–35. https://doi.org/10.1159/000441111

Priestley, M. (1994). *Essays on analytical music therapy*. Barcelona Publishers.

Rylaarsdam, L., & Guemez-Gamboa, A. (2019). Genetic causes and modifiers of autism spectrum disorder. *Frontiers in Cellular Neuroscience*, *13*, 385. https://doi.org/10.3389/fncel.2019.00385

Shore, S. M., (2006). The secrets of self-advocacy: How to make sure you take care of you. *Autism Advocate, 44*(4).

Stern, D. N. (2000). *The interpersonal world of the infant* (1st ed.). Basic Books.

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APPROACHES

ΒΙΒΛΙΟΚΡΙΤΙΚΗ

Η μουσική θεραπεύει: Η θεραπευτική δράση της μουσικής στις αναπτυξιακές διαταραχές (Μαντζίκος)

Κριτική από την Άρτεμις Χριστοδούλου
Ανεξάρτητη επιστήμονας, Ηνωμένο Βασίλειο

Τίτλος: Η μουσική θεραπεύει: Η θεραπευτική δράση της μουσικής στις αναπτυξιακές διαταραχές **Συγγραφέας:** Κωνσταντίνος Μαντζίκος **Έτος δημοσίευσης:** 2015 **Εκδότης:** IWRITE.GR **Σελίδες:** 278 **ISBN:** 9786185067670

ΒΙΟΓΡΑΦΙΑ ΚΡΙΤΗ
Η **Άρτεμις Χριστοδούλου** σπούδασε ψυχολογία στο Πάντειο πανεπιστήμιο από όπου και αποφοίτησε το 2010. Το 2014 ολοκλήρωσε το μεταπτυχιακό πρόγραμμα σπουδών στη μουσική ψυχολογία-μουσικοθεραπεία στο πανεπιστήμιο της Jyväskylä στην Φινλανδία (MA Music Psychology, Major Music Therapy). Από το 2019 εργάζεται ως μεσολαβήτρια παρεμβάσεων (interventions facilitator) σε σωφρονιστικό κατάστημα στο Ηνωμένο Βασίλειο. [artemis.chr@gmail.com]

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Το βιβλίο *Η Μουσική Θεραπεύει*, γραμμένο από τον Κωνσταντίνο Μαντζίκο, ασχολείται με την επίδραση της μουσικής στον άνθρωπο, το νου και τα συναισθήματα. Ο συγγραφέας ορμώμενος από τις δικές του εμπειρίες με τη μουσική και στην καριέρα του ως εκπαιδευτικός ειδικής εκπαίδευσης, οδηγήθηκε στη μελέτη επιστημονικών βιβλίων και άρθρων τα οποία θα του έδιναν τη δυνατότητα να αναγνωρίσει και να εκτιμήσει τη δύναμη της μουσικής σε θεραπευτικά πλαίσια. Το βιβλίο χωρίζεται σε 6 μέρη με αρκετά διαφορετικές θεματικές και σημεία εστίασης.

Στο πρώτο μέρος ο συγγραφέας ανατρέχει στις διαφορετικές θεραπευτικές χρήσεις και πρακτικές της μουσικής από την αρχαιότητα και τη μυθολογία μέχρι σήμερα. Περιγράφει τη χρήση της μουσικής και την αντίληψή της ως θεραπευτική από τους σύγχρονους της εποχής σε μέρη όπως η Αίγυπτος, η Ελλάδα, η Ινδία, η Κίνα και το Θιβέτ, ενώ γίνεται αναφορά και στην ισλαμική κουλτούρα. Αναφέρεται στη χρήση της μουσικής για συναισθηματική υγεία κατά τη διάρκεια της Αναγέννησης και φτάνει στη σύγχρονη μουσικοθεραπεία και την ύπαρξή της στην Ευρώπη και τις ΗΠΑ. Σε αυτό το πρώτο μέρος ο Μαντζίκος αναφέρεται περισσότερο στην επίσημη καθιέρωση του επαγγέλματος παρά στο τι σημαίνει σύγχρονη μουσικοθεραπεία.

Στο δεύτερο μέρος γίνεται αναφορά σε διάφορους ορισμούς της μουσικοθεραπείας κυρίως προερχόμενους από τις ΗΠΑ, τη Γερμανία και τη Παγκόσμια Ομοσπονδία Μουσικοθεραπείας. Γίνεται αναφορά σε πιθανούς τρόπους χρήσης της μουσικής σε διαδικασίες διάγνωσης και αξιολόγησης με κύρια πηγή την πτυχιακή εργασία με τίτλο *Ειδικές Θεραπείες στο Χώρο της Ψυχικής Υγείας* (Τάτση & Τσούτση, 2007), στην οποία γίνονται σύντομες αναφορές σε διάφορες θεραπείες μέσω τεχνών όπως η δραματοθεραπεία, η παιγνιοθεραπεία και η εικαστική θεραπεία. Θα ήταν ίσως ενδιαφέρον να γίνει αναφορά και σε διαγνωστικές μεθόδους προτεινόμενες σε

επιστημονικές δημοσιεύσεις όπως αυτές της Baxter (2007) και των Jacobsen και συνεργατών (2018) που έχουν γραφτεί με ξεκάθαρη έμφαση στη μουσικοθεραπεία από επαγγελματίες του χώρου. Στη συνέχεια γίνεται ανάλυση του ρόλου του μουσικοθεραπευτή, των ικανοτήτων που θα πρέπει να έχει τόσο ως μουσικός όσο και ως θεραπευτής, καθώς και της ανάπτυξης των δεξιοτήτων του, ώστε «να λαμβάνει και να κατανοεί τα μηνύματα που του στέλνουν οι ασθενείς του» (σ. 45). Το δεύτερο μέρος κλείνει με επικέντρωση στη χρήση και τη χρησιμότητα της μουσικοθεραπείας στην εκπαίδευση και ακόμη περισσότερο στην ειδική αγωγή σε ομαδικό καθώς και σε ατομικό επίπεδο.

Στο τρίτο μέρος του βιβλίου γίνεται αναδρομή σε διάφορες έρευνες που έχουν γίνει σχετικά με την επίδραση της μουσικής στον εγκέφαλο, στη συμπεριφορά, στη μουσική αντίληψη, στη μνήμη, στη γλώσσα, στα συναισθήματα και στην κίνηση. Είναι πολύ ενδιαφέρον να διαβάσει κανείς τον τρόπο που η μουσική επιδρά στα παραπάνω και θα ήταν ίσως θεμιτό να υπάρχει περισσότερη ανάπτυξη του κάθε κεφαλαίου και πιο εκτενείς πληροφορίες για το πώς χρησιμοποιείται θεραπευτικά η μουσική στα κλινικά πλαίσια που αναφέρονται.

Στο τέταρτο μέρος ο συγγραφέας επικεντρώνεται στην επίδραση της μουσικής σε άτομα με άνοια, νόσο του Πάρκισον, επιληψία, μαθησιακές δυσκολίες, Διαταραχή Αυτιστικού Φάσματος (ΔΑΦ), νοητική αναπηρία, σύνδρομο Tourette, οπτική αναπηρία, εγκεφαλική παράλυση και αφασία Broca. Τα κεφάλαια τείνουν να ακολουθούν παρόμοια δομή αναλύοντας πρώτα την κάθε διαταραχή/πάθηση και κατόπιν αναφέροντας τα πιθανά οφέλη της μουσικής. Το κεφάλαιο για την ΔΑΦ είναι κάπως άνισο συγκριτικά με τα υπόλοιπα καθώς είναι από τα μεγαλύτερα κεφάλαια. Ο συγγραφέας μάλιστα αναφέρει και προσωπικές του εμπειρίες με άτομα με ΔΑΦ στα πλαίσια της πρακτικής του ως φοιτητής ειδικής αγωγής σε ειδικό σχολείο, καθώς και προσωπικές εμπειρίες μιας μουσικού, που έχει διδάξει μουσική σε άτομα με ΔΑΦ. Ενώ γίνεται αναφορά σε κάποιους τρόπους θεραπευτικής χρήσης της μουσικής, θα ήταν ενδιαφέρον να υπάρξει αναφορά και σε άλλους. Άρθρα, όπως αυτά των Eren (2017) και James και συνεργατών (2015), όπου γίνεται αναφορά στις προτιμώμενες μεθόδους από μουσικοθεραπευτές στις Η.Π.Α. αλλά και σε έρευνες μουσικοθεραπείας που έχουν πραγματοποιηθεί και στις μεθόδους που χρησιμοποιήθηκαν είναι ορισμένα παραδείγματα όπου περιέχονται εκτενείς αναφορές στη θεραπευτική χρήση της μουσικής για άτομα με ΔΑΦ και θα μπορούσαν να εμπεριέχονται σε αυτό το μέρος του βιβλίου.

Το πέμπτο μέρος αποτελείται από κεφάλαια σχετικά με την επίδραση της μουσικής σε άτομα με χρόνιο πόνο, καρκίνο, εγκαύματα, καρδιακά προβλήματα, αϋπνία, αγχώδη διαταραχή και κατάθλιψη. Θα ήταν ενδεχομένως ενδιαφέρον στο συγκεκριμένο κεφάλαιο να υπάρχει περισσότερος πλουραλισμός σε ότι αφορά τις έρευνες που αναφέρονται στην επίδραση της μουσικής δεδομένης της πληθώρας ερευνών στον χώρο. Με αυτόν τον τρόπο θα μπορέσουν να φανούν διαφορετικές μέθοδοι που χρησιμοποιούνται από μουσικοθεραπευτές για την αντιμετώπιση των παραπάνω, καθώς και διαφορετικές μεθοδολογίες που χρησιμοποιούνται από ερευνητές που διερευνούν τα αποτελέσματα της χρήσης της μουσικής. Η Lee (2015) αναφέρει, για παράδειγμα, πως ανέλυσε 14 συστηματικές ανασκοπήσεις άρθρων οι οποίες συμπεριέλαβαν συνολικά 97 έρευνες για τη διαχείριση του πόνου με τη βοήθεια της μουσικής.

Το έκτο και τελευταίο μέρος του βιβλίου αφορά τη μουσική του εσωτεριστή φιλοσόφου Gurdjieff και τη μουσική του μουσικοσυνθέτη Mozart. Το συγκεκριμένο κεφάλαιο αποτέλεσε μια ιδιαίτερη εισαγωγή για τη φιλοσοφία και τη μουσική του Gurdjieff, στηριζόμενο κυρίως στα

γραπτά του Rosenthal. Το κεφάλαιο για το Μότσαρτ αναφέρθηκε περισσότερο σε έρευνες που έχουν γίνει για την επίδραση της μουσικής του, καθώς και για την ποιότητα της μουσικής του.

Ο υπότιτλος του βιβλίου, *Η Θεραπευτική Δράση της Μουσικής στις Αναπτυξιακές Διαταραχές*, παραπέμπει σε αναφορά στις διαφορετικές και πολλαπλές θεραπευτικές χρήσεις της μουσικής με άτομα με αναπτυξιακές διαταραχές. Στο βιβλίο όμως έγινε λόγος για πολλές διαταραχές και παθήσεις ανεξάρτητες των αναπτυξιακών. Η βιβλιογραφία που χρησιμοποιήθηκε θα μπορούσε να είναι κάποιες φορές πιο σύγχρονη και σε μερικές περιπτώσεις, όπως η περίπτωση της διάγνωσης με τη χρήση της μουσικής, θα ήταν χρήσιμο να γίνει αναφορά σε δημοσιεύσεις επαγγελματιών μουσικοθεραπευτών. Το βιβλίο είναι αρκετά σύντομο και γίνεται ενασχόληση με πολλά διαφορετικά θέματα χωρίς να εισχωρεί σε περισσότερο βάθος.

Δεδομένου του εύρους των θεμάτων αποτελεί μια ιδιαίτερη εισαγωγή στα αποτελέσματα που μπορεί να έχει η θεραπευτική χρήση της μουσικής σε διάφορες διαταραχές και παθήσεις. Ο συγγραφέας έχει προσπαθήσει να αναφερθεί σε πολλά θέματα και να κάνει μια ευρεία εισαγωγή για το τι είναι μουσικοθεραπεία καθώς και για το πώς μπορεί να γίνει γενικότερη θεραπευτική χρήση της μουσικής αναφερόμενος σε πολλά βιβλία και έρευνες. Ταυτόχρονα φαίνεται η προσπάθεια του συγγραφέα να δημοσιεύσει στα ελληνικά, γνώση η οποία ενδεχομένως είναι προσβάσιμη μόνο ξενόγλωσσα καθώς η πλειοψηφία των άρθρων στα οποία αναφέρεται είναι δημοσιευμένα στην αγγλική γλώσσα.

Από το βιβλίο φαίνεται το ενδιαφέρον του συγγραφέα για τη μουσική, καθώς και για τη θεραπευτική χρήση της. Ενώ στο συγκεκριμένο βιβλίο δεν προσφέρεται κάποια καινούρια γνώση αναφορικά με τη χρήση της μουσικής με θεραπευτικό τρόπο ή τη μουσικοθεραπεία, φαίνεται η προσπάθεια του συγγραφέα να κατανοήσει την ήδη υπάρχουσα γνώση και να την κάνει πιο προσβάσιμη στο ελληνόφωνο κοινό. Το συγκεκριμένο βιβλίο είναι ενδεχομένως για άτομα που θα ήθελαν να αποκτήσουν μια αρχική γνώση της θεραπευτικής χρήσης της μουσικής, καθώς και της μουσικοθεραπείας παρά από άτομα που θα ήθελαν να ασχοληθούν σε βάθος με τη θεραπευτική χρήση της μουσικής ή επαγγελματικά με τη μουσικοθεραπεία.

ΒΙΒΛΙΟΓΡΑΦΙΑ

Baxter, H. T. (2007). *The individualized music therapy assessment profile: IMTAP*. Jessica Kingsley Publishers.

Eren, B. (2017). Profiles of the most preferred and the most effective music therapy approaches being utilized with children with autism spectrum disorders according to the opinions of music therapists in the U.S. *Journal of Education and Practice*, *8*(20), 115-128.

Jacobsen, S. L., Waldon, E., & Gattino, G. (Eds.). (2018). *Music therapy assessment: theory, research, and application*. Jessica Kingsley Publishers.

James, R., Sigafoos, J., Green, V. A., Lancioni, G. E., O'Reilly, M. F., Lang, R., Davis, T., Carnett, A., Achmadi, D., Gevarter, C., & Marschik, P. B. (2015). Music therapy for individuals with autism spectrum disorder: a systematic review. *Review Journal of Autism and Developmental Disorders, 2*, 39-54. https://doi.org/10.1007/s40489-014-0035-4

Lee, J. H. (2016). The effects of music on pain: a meta-analysis. *Journal of Music Therapy, 53*(4), 430-477. https://doi.org/10.1093/jmt/thw012

Τάτση, Δ. Κ., & Τσούτση, Μ.Α. (2007). *Ειδικές θεραπείες στο χώρο της ψυχικής υγείας*. [Πτυχιακή εργασία, Αλεξάνδρειο Ανώτατο Τεχνολογικό Εκπαιδευτικό Ίδρυμα]. Ιδρυματικό Καταθετήριο Εύρηκα. http://195.251.240.227/jspui/handle/123456789/7844

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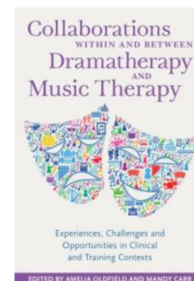
BOOK REVIEW

Collaborations within and between dramatherapy and music therapy: Experiences, challenges and opportunities in clinical and training contexts (Oldfield & Carr, Eds.)



Reviewed by Seren Haf Grime
Independent scholar, UK

Title: Collaborations within and between dramatherapy and music therapy: Experiences, challenges and opportunities in clinical and training contexts **Editors:** Amelia Oldfield & Mandy Carr **Publication year:** 2018 **Publisher:** Jessica Kingsley Publishers **Pages:** 256 **ISBN:** 978-1-78592-135-3

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As a dramatherapist who has worked for a decade in an arts therapies team in the NHS alongside music therapists, and now works for a company run jointly by a dramatherapist and music therapist, I read this book with anticipation, as I have always thought it strange, as the book says, that literature about our relationship is so limited. I am in a Playback Theatre Company with dramatherapist Gillian Downie and music therapist Robin Wiltshire, who wrote about the ways they worked collaboratively, co-facilitating a cross-modality group (Downie & Wiltshire, 2018). When we work together, we are often teasing each other about playing outside our comfort zones and encouraging each other to try new skills. Overall, that is the sense I took from the book; it is full of encouraging examples of how to be playful in the use of music and drama, how to try new ways of doing things. It explores this from a clinical and training perspective, as well as looking at how to evoke change by moving ourselves, other professionals, our clients and trainees out of our comfort zones in a safe way.

In addition, there is an interesting angle offered from the perspective of training establishments. As there is no dramatherapy course offered at the university most local to my practice (University of South Wales), I was fascinated to read about the training contexts and different styles of learning environments offered at Anglia Ruskin University in England and the Karol Szymanowski Academy in Katowice, Poland. It was inspiring to consider new possibilities, alongside

the detailed practical information; it opened up the possibility of new conversations when considering how to develop new training opportunities.

The book is particularly useful for trainees and newly qualified arts therapists and for its potential to be used in a training capacity. Most of the clinical examples are based around work with children and individuals with learning disabilities or autism. In addition, Jane Jackson and Christine West give examples of work with older adults, and Konieczna-Nowak's focus is on young people living in "socially deprived areas" (p. 167). The literature reviewed in all chapters is exceptionally thorough, but I began to skim-read these as they covered a range of underpinning theoretical material. Whilst useful from an academic perspective, they did not offer me any new material. I would like to praise the writers and editors, however, for this exceptional quality confirms the extent to which the arts therapies can be framed by a range of schools of thought. Again, this could be useful in all arts therapies training and service development. It could aid other professionals and families to gain a deeper understanding when learning why we work in the way that we do. The necessity of this in a climate where, certainly in the UK, arts therapies are feeling isolated or threatened is alluded to by Jennings (p. 26), Jackson (p. 70) Amelia Oldfield (pp. 119, 124 & 126), Ellinor and Georgaki (pp. 131 & 145) and Dokter and Odell-Miller (pp. 188-189 & 200).

For this reason, I chose not to read the book in a linear way, and read the chapters more haphazardly, reading the parts that drew my attention first. As a more established dramatherapist, what I enjoyed reading most were the historical stories by Jennings, and Dokter and Odell-Miller. The unique collaborations in 'Love Songs for My Perpetrator: A Musical Theatre-Based Drama Therapy Performance Intervention in the USA' (Reynolds & Davis) and the dramatherapy and music therapy project in Poland (Konieczna-Nowak), which also had a performative aspect, were fascinating too. Reynolds and Davis describe their love of musical theatre and how they conceive, create and perform their own musical to explore the history of their own personal process and trauma as therapists. Discussing the influence of therapeutic theatre and self-revelatory performance defined by Renee Emunah, they state "Upon reflection, we believe our piece was deliberately both types of therapeutic theatre at once" (p. 154).

Similarly, the project in Poland describes a "reality-oriented model" and a "metaphor-oriented model" (p. 170). It seems in both these chapters that the collaborative use of drama and music has enabled the possibility of improvising and developing innovative, inspirational ways of working. The coming together of modalities offers a stronger holding container in which imagination can thrive. Many of the authors comment that this process does not only enable the client in finding their voice, but also themselves. Konieczna-Nowak shares "For me as a music therapist, seeing dramatherapy in action, and working with other professionals is always inspiring, and I bring fresh ideas to all my work, also in the purely music area" (p. 183).

Oldfield's chapter 'Humour, Play, Movement and Kazoos' was very easy to read and made me smile. On the first day I met my new team, one of the music therapists taught me how to play the kazoo and it broke the ice, bringing much laughter. I immediately felt less nervous within my new team, who have also written about working collaboratively (Cropper & Godsal, 2016). Oldfield offers clinical examples of those first moments of attachment and states "[in] these examples sound, music and humour are closely interwoven, and the efficacy of the interaction is dependent on the combination of these three elements" (p. 115).

The outcomes of working with both drama and music as a music therapist and dramatherapist are shown to be beneficial especially newly found freedom and spontaneity through creative expression and play. Improved communication and understanding, language skills and non-verbal competencies, as well as improved emotional communication and interpersonal communication are described. Increased motivation, choice and autonomy are reported. Improved kinaesthetic and musical rhythmic awareness, increased reflective ability and opportunity to experience feelings of trust, confidence and enjoyment are echoed throughout. The book illustrates that whether you are meeting with a new-born, an 80-year-old or anyone in between, dramatherapists and music therapists have so much to offer each other, positively influencing clinical content and peer support and supervision.

I am writing this whilst shielding during lockdown due to Covid-19, and one of the things that has kept me sane is the access to musical theatre and theatre productions on screen. Watching a live performance of a musical or play on the screen added a different dimension to the experience. It is a good metaphor for the experience of reading this book; reading, in print, a written production of a live creative relationship which has led to collaboration and innovation rather than cuts and competition. It certainly inspired me to be a fellow pioneer and to dig out my kazoo!

REFERENCES

Cropper, K., & Godsal, J. (2016). The useless therapist: Music therapy and dramatherapy with traumatised children. *Therapeutic Communities: The International Journal of Therapeutic Communities, 37*(1), 12-17.

Downie, G., & Wiltshire, R. (2018). Stretch marks: An exploration of a joint dramatherapy and music therapy group. In T. Colbert & C. Bent (Eds.), *Working across modalities in the arts therapies* (pp.69-80). Routledge.

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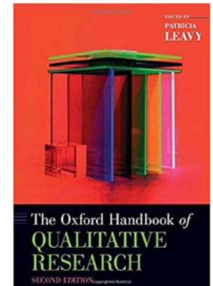
APPROACHES

BOOK REVIEW

The Oxford handbook of qualitative research (2nd ed.) (Leavy, Ed.)



Reviewed by Barbara L. Wheeler
Montclair State University, USA

Title: The Oxford handbook of qualitative research (2nd ed.) **Editor:** Patricia Leavy **Publication year:** 2020 **Publisher:** Oxford University Press **Pages:** 1280 **ISBN:** 9780190847388

REVIEWER BIOGRAPHY
Barbara L. Wheeler, PhD, MT-BC, holds the designation of Professor Emeritus from Montclair State University, where she taught from 1975-2000. She initiated the music therapy program at the University of Louisville in 2000, retiring in 2011. She presents and teaches in the U.S. and internationally and has been an active clinician throughout her career. Barbara edited or co-edited three editions of *Music Therapy Research,* edited *Music Therapy Handbook*, and is co-author of *Clinical Training Guide for the Student Music Therapist*. She received a Lifetime Achievement Award from the World Federation of Music Therapy and from the American Music Therapy Association. [barbara.wheeler@lousiville.edu]

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The Oxford Handbook of Qualitative Research, 2nd edition, is an enormous book, as are most of the Oxford handbooks. As such, it provides an opportunity to learn about diverse topics in qualitative research. Because it is an edited book, the information is presented from various perspectives.

The second edition is revised and expanded from the first edition, which was published in 2014. The first edition had 600 pages, while the current edition has more than twice that number. According to the editor, Patricia Leavy, the chapters that were included in the first edition have been updated, with seven chapters added.

The editor suggests that the book can be useful to those with little or no background in qualitative research as well as experienced researchers and that it can be used in undergraduate and graduate courses and by those working on theses and other research projects. This has prompted me to consider how music therapists might use this book. While I can certainly picture an undergraduate reading a chapter from the book, it is difficult for me to see an undergraduate music therapy student (or student in another major) using the book extensively, so describing it as suitable for an undergraduate course does not seem realistic. Moving beyond the undergraduate level, one of my concerns is that music therapy scholars do not utilize the literature that is available as well as we should. Of course, my experience is limited to those people and situations with whom I have contact: Students with whom I have worked (at all levels and from many countries); theses, dissertations, and articles that I have reviewed and read; workshop and individual interactions. It seems to me that music therapists would benefit from reading more of the literature that is available, which would include chapters from this book. My own use of the book will be primarily for scholarly work, and I will consult

it when preparing course outlines, lectures, or presentations, and when writing about aspects of qualitative research.

I have considered the *Sage Handbook of Qualitative Research* (Denzin & Lincoln, 2017), now in its fifth edition, to be the standard handbook for qualitative research. I have several of these volumes in my library, which I have used regularly over the years, so I read this *Oxford Handbook* with the Sage books in mind. The table below compares the books on several points:

	Oxford	Sage
Date of first edition	2014	1994
Date of current edition	2020	2017
Number of current edition	2	5
Cost of hardcover version	$230	$150
Number of chapters	40	41
Number of pages	1280	992

Table 1: Comparison of Oxford and Sage handbooks

The content of many of the chapters of the *Oxford Handbook* (as well as the *Sage Handbook*) is what I consider standard for a book on qualitative research. This includes chapters on the history of qualitative research, philosophical underpinnings (as part of a chapter on philosophical approaches), and ethics. Many of the chapters on approaches to or methodologies for qualitative research are also as expected, including those on grounded theory, feminist approaches, critical approaches, narrative inquiry, content analysis, and case study research. Other expected chapters are on analysis and interpretation and on writing up qualitative research (with coverage of writing expanded in this edition).

Looking at the tables of contents of the two, it seems to me that the *Oxford Handbook* includes chapters with less traditional content than do the *Sage Handbooks*. The content, of course, is a decision of the editor, and Patricia Leavy takes responsibility for her choices. Some of the chapter content that I find unusual was also a part of the first edition, so I assume that she considers it important. Examples of the topics to which I am referring are: duoethnography (new in this edition), museum studies, photography as a research method, Internet-mediated research, and qualitative disaster research. These chapters point the reader to newer directions, which can be positive.

I found some of the chapters to be fascinating and will mention just a few of them. The chapter titled "Historical Overview of Qualitative Research in the Social Sciences" presents six histories of qualitative research, which can be considered "articulations of different discourses about the history of the field, which compete for researchers' attention" (p. 24). These include the conceptual, the internal, the marginalizing, the repressed, the social, and the technological histories of qualitative research. All help to understand this history. The chapter "Feminist Qualitative Research" was informative to me. It provides an overview of feminist research and discusses what feminist research seeks to correct, feminist epistemology, how feminist research is used for the study of sex/gender differences, the values of feminist research, challenges to feminist research, and forms of feminist qualitative research. Other chapters that I found especially instructive are "Practicing Narrative Inquiry

II" and "Practicing Autoethnography and Living the Autoethnographic Life." Finally, I found the "Program Evaluation" chapter to be very interesting. I have not listed nearly all of the chapters that I found interesting or useful, but if I were using this book in teaching, these are among those that I would have my students study.

Five chapters present aspects of writing up qualitative research and provide a broad overview, with each contributing unique points. This coverage of presenting qualitative research is part of what the editor says has been expanded in this edition in a way that she hopes is of value to students, professors, and researchers. In my assessment, this is a valuable expansion and contribution. I also find the chapter on evaluation, which suggests five categories for evaluating qualitative research, to be very helpful.

I would like to connect the contents of this book to qualitative research in music therapy. When Aigen (2008a, 2008b) investigated the methods used in qualitative research in music therapy a number of years ago, qualitative research used phenomenological inquiry than any other method. However, phenomenological inquiry is not among the chapters in either the *Oxford* or *Sage Handbook* (although it is covered as a philosophical tradition that informs qualitative research in the historical overview chapter of the *Oxford Handbook*). Aigen also reported a number of studies using constructivist/ naturalistic methods, also not included in either of these handbooks, and grounded theory, which is included.

As I read the chapter on arts-based research, I wonder how we can make those outside of music therapy more aware of our own qualitative research. The chapter authors, Chilton and Leavy, in a note to the chapter, say that they have chosen to focus on the practices with which they have the most experience and that they believe are most widely used. I think, though, that they have missed an opportunity by not including arts-based music therapy research. The chapter by Viega and Forinash (2016) in *Music Therapy Research*, 3rd edition (Wheeler & Murphy, 2016) provides an overview of arts-based research in music and music therapy and includes 17 examples of music therapy studies. It is disappointing, therefore, that no music therapy arts-based research studies are cited in the current chapter. This may mean that arts-based researchers in music therapy need to publish their studies in sources that are more available to those outside of music therapy, or that those outside of music therapy are not searching diligently for music therapy studies.

In summary, this very large book provides information on many aspects of qualitative research and can be of value to music therapy students, researchers, and scholars. I encourage music therapists to take advantage of what it has to offer. Patricia Leavy says in the Preface (p. xxi); "My hope is that the handbook will be useful in the teaching of qualitative research to students across disciplines and that researchers will frequently pull it from their bookshelves." I believe that it serves this purpose.

REFERENCES

Aigen, K. (2008a). An analysis of qualitative music therapy research reports 1987–2006: Articles and book chapters. *Arts in Psychotherapy, 35*(4), 251–261. doi:10.1016/j.aip.2008.06.001

Aigen, K. (2008b). An analysis of qualitative music therapy research reports 1987–2006: Doctoral studies. *Arts in Psychotherapy, 35*(5), 307–319. doi:10.1016/j.aip.2008.06.001

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2017). *The Sage handbook of qualitative research* (5th ed.). Sage.

Viega, M., & Forinash, M. (2016). Arts-based research. In B. L. Wheeler & K. M. Murphy (Eds.), *Music therapy research* (3rd ed., pp. 492-504). Barcelona Publishers.

Wheeler, B. L., & Murphy, K. M. (Eds.). (2016). *Music therapy research* (3rd ed.). Barcelona Publishers.

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APPROACHES

CONFERENCE REPORT

The 5th International Conference of Dalcroze studies (ICDS5) 'Dalcroze practice in diverse cultures, communities and contexts'

Anna Harrison
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CONFERENCE DETAILS

The 5th International Conference of Dalcroze studies (ICDS5)
"Dalcroze practice in diverse cultures, communities and contexts"
22-23 October 2021, online

AUTHOR BIOGRAPHY

Anna Harrison is an Australian violinist currently based in the UK. Harrison has recently completed a Master of Music in Performance and Music Psychology with distinction from the Royal Northern College of Music (RNCM) and is currently studying a Master of Science in Psychology at the University of Wolverhampton. Harrison is a freelance musician and has worked as an instrumental teacher and a play leader at Songbirds Music UK delivering specialised music projects to children and families affected by medical conditions, hospitalisation and disability. [annaharrison.violin@gmail.com]

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INTRODUCTION

The 5th International Conference of Dalcroze Studies (ICDS5) was held on the 22nd and 23rd of October 2021 (ICDS, 2021). Due to the pandemic, this biennial conference was initially postponed and then moved online for the first time. Dalcroze practitioners and those from related fields, students and established scholars were all welcomed as presenters. Attendees represented countries from all over the globe with the online forum possibly increasing accessibility for the many diverse participants (350 in total). The benefit of accessibility gained from the online structure of the conference balanced some of the inconveniences of communicating through technology. The conference theme was 'Dalcroze practice in diverse cultures, communities and contexts.' This theme encouraged discussion and celebration of the relationships between people, practice, and place in Dalcroze study and related practices.

Photograph 1: Conference logo

Dalcroze Eurhythmics (DE) entails carefully facilitated exercises centred on the body as a means for embodied experiences (Jaques-Dalcroze, 1921, 1925). DE was developed by Émile Jaques-Dalcroze (1865-1950) with the intention of awakening connection between the body, mind and emotions through exercises engaging music and movement. Directed movement exercises encourage attention to detailed nuances of physical

actions which can lead to a more holistic sense of self. As Juntunen and Hyvönen (2004) explain, Dalcroze practice calls for constant "awareness of kinaesthetic sensations. The goal is to show music's heard and felt qualities in body movement" (p. 203). Greenhead and Habron (2015) contextualise this by explaining that "for Jaques-Dalcroze, music was not only the goal of study; it was also the means to discovery, of developing skilfulness and of personal transformation" (p. 103). ICDS5 provided a space for such discovery and collaboration through listening to others' experiences and performances as well as actively workshopping.

ICDS5's technical operation was headed by four Regional Coordinators (Andrew Goldman, Stephen Neely, Alexander Riedmüller, and Katherine Smith), with each providing online infrastructure in their respective time zones. Their preparation and collaboration were evident in the smooth facilitation of forums (up to six parallel sessions at times) that helped attendees come together meaningfully despite being all in our own spaces across the globe. The conference also made videos of the presentations available to all participants for a fortnight after the event.

Throughout ICDS5, presentations explored incredibly varied applications of the principals of Dalcroze pedagogy to music, dance, education, performance, therapy and somatic practices. There were many inspiring presentations in an abundance of formats from symposiums, workshops, roundtables, posters, papers and performances, to an online chat forum for informally meeting other delegates. Each presentation was unique and offered thought-provoking perspectives on Dalcroze theory, history or practice. There was a mixture of research methodologies utilised, from historical research, practice-based research, art-based research, to autoethnographic research and many more. Underpinning this variety was the participants' shared focus, curiosity and willingness to listen, argue and learn from each other. Personally, I was honoured to present alongside Bethan Habron-James, Diane Daly and Rosalind Ridout in a symposium on the use of autoethnography in Dalcroze practice and research. I also presented an autoethnographic paper which explored my experience as a Dalcroze student and the unexpected benefits this had on my negative body image. I drew on parallels between my experience of Cognitive Behavioural Therapy (CBT) and Dalcroze. Both start with a breaking down of issues or tasks to focus on individual components. CBT taught me to observe myself objectively without falling into self-criticism and then built up alternate self-talk. Then Dalcroze taught me to become aware of and actively embody free but intentional movements through observation and action. The exercises grew in complexity over the classes and provided a regular supportive space in which to consciously engage with my body and with others. This way of working with and thinking about my body further promoted self-acceptance and a resilient mindset. As a presenter, I appreciated the willingness of attendees to actively listen, as this supported an atmosphere for deeply delving into often quite personal topics and experiences. Throughout the conference, there was a sense of the importance of embracing diversity with courage and openness. To paraphrase Ava Loiacono; Education is the most powerful tool we have to fight injustices and inequalities (Giovanardi et al., 2021). The nature of Dalcroze practice lends itself well to a diverse range of abilities and ages. Intersections between music therapy, arts-based therapies and Dalcroze are active and living withing the Dalcroze community.

Three keynote speakers from different backgrounds and countries gave thoughtful insights, highlighting different aspects of the conference theme. The opening keynote speaker was the current UNESCO Chair in Dance and Social Inclusion, Nicholas Rowe from the University of Auckland, New Zealand. He spoke of the current and imminent challenges we face as arts educators, students and practitioners due to politically, economically or environmentally forced mass migration globally. He elaborated on the significance of performing arts educators in aiding cultural integration in response to the challenges of a strong and often unconscious impetus towards acculturation. He deftly guided the discussions of artistic practice into the realms of social awareness.

The theme of diversity elicited contemporary insights into Dalcroze studies and the exploration of relationships between people, practice, and place. The second keynote speaker was Kathryn Kay, a Dalcroze Eurhythmics teacher at the Royal College of Music, UK. She shared some of her approaches and experiences of teaching children from diverse backgrounds. Kay explored how she had facilitated increased access to

music-making online during COVID-19 lockdowns when students were perhaps less active or in tune with their bodies. Her presentation encouraged participants to engage with and think of the human body as the most expressive, skilled, beautiful and intelligent instrument we can use to experience the world around us.

ICDS5 also highlighted the use of Dalcroze practice to build bridges across geographical and cultural boundaries even in unanticipated contexts. The final keynote speaker was Liesl van der Merwe from North-West University, South Africa. She presented an exploration of joy as a concept that runs throughout Jaques-Dalcroze's writings. Her original theory examined the conditions for experiencing joy and its transformative consequences, for example joyful experiences promote optimism and curiosity in the Dalcroze classroom. Van der Merwe demonstrated these concepts with beautiful stories and recollections about using Dalcroze in promoting joyful experiences and even conflict resolution in diverse communities in South Africa. There was a strikingly memorable moment as she guided us into an exercise of moving together to a lively piece of music. All the straight faces on the Zoom matrix loosened and eventually erupted in laughter as we joined in wholeheartedly. Her energetic delivery explained this connection: "When we move together, it just makes us stronger".

In an active embodiment of the theme, this conference encapsulated a rich diversity of experiences. Dalcroze practitioners, scholars and students demonstrated that they are continuously evolving and adapting their practices. As Jaques-Dalcroze put it:

> The more we have of life, the more we are able to diffuse life about us… music is a tremendous… force: a product of our creative and expressive functions that, by its power of stimulating and disciplining, is able to regulate all our vital functions. (Jaques-Dalcroze, 1921, p. 155)

Presenters at the conference showed that the practice of Dalcroze had potential to build connections and promote physical and mental well-being, and resilience.

This conference could be seen as growing from Jaques-Dalcroze's (1921) idea that "the aim of eurhythmics is to enable pupils, at the end of their course, to say, not "I know", but "I have experienced" (p. 155). ICDS5 celebrated achievements and looked towards possible future applications of Dalcroze and related research in arts, education, humanities, and the natural, social, life and health sciences. Insights grew from a conscious effort of practitioners and researchers to recast Dalcroze study and practice in the light of contemporary society. Many thanks to John Habron, Chair of the Scientific Committee, and the ICDS team for providing a platform for seeking to uncover the deeper meanings and possibilities in the legacy of Jaques-Dalcroze. This conference was a thought-provoking sharing of knowledge and experience. Dalcroze continues to evolve as a living practice.

The next ICDS will be held in 2023. Further information and updates about when and where it will be held can be found here: https://www.dalcroze-studies.com

REFERENCES

Giovanardi, E., Loiacono, A., & Sacchi, R. (2021, October 22-23). *Dalcroze spazio aperto - Dalcroze open space* [Conference presentation]. ICDS5 2021, Online. https://www.dalcroze-studies.com

Greenhead, K., & Habron, J. (2015). The touch of sound: Dalcroze Eurhythmics as a somatic practice. *Journal of Dance & Somatic Practices, 7*(1) 93-112. http://dx.doi.org/10.1386/jdsp.7.1.93_1

ICDS (2021). *Welcome to the 5th international conference of Dalcroze studies*. International Conference of Dalcroze Studies. https://www.dalcroze-studies.com

Jaques-Dalcroze, E. (1921/1967). *Rhythm, music & education*. The Dalcroze Society.

Jaques-Dalcroze, E. (1925). The nature and value of rhythmic movement. In *Eurhythmics Art and Education*. Ayer Company Publishers, Inc.

Juntunen, M., & Hyvönen, L. (2004). Embodiment in musical knowing: How body movement facilitates learning within Dalcroze Eurhythmics. *British Journal of Music Education, 21*(2), 199-214. https://doi.org/10.1017/S0265051704005686

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APPROACHES

CONFERENCE REPORT

Music and medicine: Musicological and medical-historical approaches

John Habron
Royal Northern College of Music, UK

CONFERENCE DETAILS

Annual conference of the Association for the Social History of Medicine
'Music and medicine: Musicological and medical-historical approaches'
4-6 November 2021, Online

AUTHOR BIOGRAPHY

John Habron PhD is Head of Music, Health, and Wellbeing at the Royal Northern College of Music, Manchester and Extraordinary Associate Professor in the MASARA (Musical Arts in South Africa: Resources and Applications) research entity at North-West University, South Africa. Having trained as a composer and music therapist, he now undertakes transdisciplinary research with particular interests in the practice-based, theoretical, and historical connections between music, movement, and wellbeing. His research has appeared in *Psychology of Music*, *Journal of Research in Music Education*, and *Journal of Dance and Somatic Practices*. In 2016, John guest-edited a special issue of *Approaches: An Interdisciplinary Journal of Music Therapy* (Dalcroze Eurhythmics in Music Therapy and Special Music Education). He is currently on the editorial board of the *International Journal of Music Education* and has chaired the Scientific Committee of the International Conference of Dalcroze Studies (ICDS) since its founding in 2013. [john.habron@rncm.ac.uk]

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It is always useful to have one's approaches to practice and research thrown into a new light by interacting and exchanging across disciplinary boundaries. This conference provided just such an opportunity. The call for papers stated that

> musicology and music historiography have hardly benefited from the socio-historical perspectives in medical history under the sign of the patient history turn since the late 1990s, and more recent methodological and conceptual considerations within musicology and multidisciplinary sound studies have so far hardly been noticed, even in the cultural historically oriented fields of medical history. (Heidegger & Pavlović, 2021)

The 25 presentations responded admirably to this challenge and to the special welcome given to contributions with a patient-oriented, gender-critical or decolonizing focus.

Several organisations collaborated to mount the event: the Association for the Social History of Medicine; at the University of Innsbruck, the Department of History and European Ethnology, the Department of Music, and the Research Centre Medical Humanities; and the Music Collection of the Tyrolean State Museums.

This confirmed the interdisciplinary nature of the event and in the relaxed yet focused atmosphere interesting dialogues developed between scholars from different fields, such as musicology and the history of medicine, historical sound studies and music therapy. Many of the papers focused on patients as music makers and music listeners, the metaphors used to describe music making, and how sound experiences in contexts of health and wellbeing are embodied. The range of contexts was extremely broad in terms of geography, time period, and culture, as shown by the following five examples.

In her examination of J.C.F. Rellstab's Anleitung für Clavierspieler (1790), Marie-Louise Herzfeld-Schild (Vienna) examined the author's emphasis on the importance of the nerves in piano playing. She noted how Rellstab was influenced by contemporary physiological understandings of the nerves, themselves based on musical principles. Physicians compared nerves with musical strings and proposed a proportional relationship between movement in the nerves and the sensations felt. Nerve constitution also influenced a person's temperament (e.g., choleric and sanguine). Thus, Herzfeld-Schild traced how ideas about music physiology moved between doctors, composers, and music publishers.

Naomi Joy Barker (Open University, UK) took us to the Ospedale di Santo Spirito in Sassia in early seventeenth-century Italy. Her focus was the organ in the ward, used in Christian worship and played at mealtimes for "the recreation of the sick." Given there are no accounts of the music played, Barker considered whether the repertoire could have included the Libro Primo di Capricci (1624) by Girolamo Frescobaldi, who worked at the hospital. One point centred on the composer's use of the cuckoo motif. Was Frescobaldi's 'Cuckoo Capriccio' the equivalent of looking at the painting of a landscape in a gallery as a substitute for being outside in the fresh air (something recommended at the time for those who were not well enough to go outside)? In this way, Barker made a closely argued case for these pieces being part of the hospital's approach to treatment, especially of patients' moods.

The practice of music in medicine and psychiatry in nineteenth-century Vienna was the focus of Andrea Korenjak (Vienna). Relying on medical dissertations of the period, she outlined the ways authors found music to be therapeutic, namely: music for amusement; music as a reward (and its withdrawal as disciplinary measure); and music as a distraction from mental illness. Korenjak also summarised six recommendations for practice, extracted from her sources. She noted that one of these (music must be introduced slowly in accordance with the patient's frame of mind) resonated with the iso principle articulated by American music therapist Ira Altshuler in the 1940s (Gouk, 2001). Given this theory still has currency (I studied it on my music therapy training), we can see how elements of contemporary practice can have long histories.

Bernd Brabec de Mori (Innsbruck) spoke about European interpretations of non-European sound techniques in the context of shamanism in the Western Amazon. Through five years of ethnographic work, he explored what he calls indigenous sonic ontologies, for example the practice of healers singing to patients, invoking spirits or animal entities to bring about change. However, he warned that these techniques are inapplicable in modern medical, wellbeing, and therapeutic practice, yet they are becoming psychologized by observers in ways that are "intrinsically based on deep coloniality."

Finally, Sarah Koval (Harvard) based her paper on an unlikely archival source, a seventeenth-century English recipe book that included notations of pieces for cittern. She showed us how the book's owners, John Ridout and Susana Cox, had crafted knowledge in a "domestic laboratory." Koval examined the notion of 'music as recipe', a prescription for taking (musical and medicinal) actions. Even though using a rudimentary tablature, the music notation mirrored the recipes in reflecting an embodied, experimental, and self-directive practice. In these ways, Koval read these books as meaningful compilations of prescriptions for enacting ephemeral phenomena (food, medicines, and music performance).

To give a taste of the sheer variety and richness of presentations, other papers focused on topics such as: bathing and spa music in the early modern period (1450–1750) (Lorenz Adamer, Tubingen); hymns as poisons or antidotes in interconfessional conflict in the eighteenth-century (Markáta Vlková, Brno); John Conolly

(1794-1866), superintendent at Hanwell Asylum, and his writings on the ideal use of music as therapy and moral management (Rosemary Golding, London); music performance anxiety and its particular manifestation in connection with political and racial persecution in 1930s Germany (Regina Thumser-Wöhs, Linz); the representation of diabetes in three late twentieth-century operas (Emile Wennekes, Utrecht); how musical attention towards performances by the Islamic Aissawa Brotherhood was influenced by medical and colonial ideologies in nineteenth-century France (Céline Frigau Manning, Lyon); and the meanings that musical and other cultural activities held for visitors to sanatoriums in Sweden 1891-1961 (Karin Hallgren, Växjö).[1]

Taking a microhistorical approach, my own paper focused on the music therapy pioneer Priscilla Barclay and especially the patients she worked with at St. Lawrence's Hospital, Caterham, England (1956-1977). As such, it presented one of the more recent instances of music in the service of wellbeing at the conference. This was the first time I had presented this research to an audience drawn from the interdisciplinary fields of the medical humanities and the social history of medicine, and I was gratified to receive several interesting and thought-provoking questions.

While many papers considered positive relationships between music, health and wellbeing, presenters did not shy away from discussing the possible instrumentalization of the music-medicine connection in biopolitics, such as through violence over mind and body in war. Some examined the abuses of music and sound in contexts such as discipline, punishment, and even torture.[2] Not least among these was the conference keynote, Morag Josephine Grant (Chancellor's Fellow in Music at the University of Edinburgh), whose presentation was entitled 'Bleed a little louder: Sound, silence and music torture.' Starting with military punishments (flogging) undertaken by drum boys, she began to shine a light on connections between music, sound, and torture. Covering issues such as sensory deprivation (for example, silence), extreme volume, and the use of sound in rites of humiliation, Grant reminded us that psychological violence leaves no visible wound. She added that authorities bent on this kind of violence are well aware of the potential of "non-corporal injuries" to do harm. In a wide-ranging presentation, Grant drew on music neuroscience, cultural studies, and ritual theory to help us make sense of music and sound used for violent ends. "Thinking though these practices," she said, "could help us to think again about what music is doing in other practices."[3]

In the opening and closing sessions, participants were treated with photographs of the University of Innsbruck, showing the snow-topped mountains in the background. Were it not for the COVID-19 pandemic, we would have met in person and enjoyed the beautiful city and its surroundings first-hand. Nevertheless, an air of friendliness and collegiality pervaded the proceedings, even though mediated through our computer screens. Delegates in Innsbruck were able to attend a concert on the last night of the conference, and this was available to others via zoom.

As a bi-lingual conference (German and English), abstracts of German presentations were available in English beforehand. Many non-native speakers spoke in English and in one case the presenter spoke in German with slides in English. These efforts at making the papers accessible for non-German speakers were much appreciated. For this and many other aspects of the organisation, Maria Heidegger and Milijana Pavlović deserve our congratulations and heartfelt thanks. We look forward to the publications (for example a special edition of the open access journal Virus: Contributions to the Social History of Medicine) and any future events that take these fascinating dialogues further.

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[1] The full conference programme is available here: https://www.uibk.ac.at/musikwissenschaft/aktuelles/events/2021/pdfs/programm-mit-abstracs-und-bios.pdf

[2] See also the Music and Violence Special Interest Group of the American Musicological Society: https://www.musicology.org/networks/sg/music-and-violence

[3] This quote was taken from my notes.

REFERENCES

Gouk, P. (2001). Objective science or just a metaphor? The 'iso' principle of Ira Altshuler. *Nordic Journal of Music Therapy, 10*(1), 65-68. https://doi.org/10.1080/08098130109478018

Heidegger, M., & Pavlović, M. (2021). *Music and medicine: Musicological and medical-historical approaches*. Call for Papers, https://www.uibk.ac.at/musikwissenschaft/aktuelles/events/2021/pdfs/cfp-musik-und-medizin.pdf

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