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EDITORIAL

'How are you going, river?' Moving through times of change together

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I was delighted to join the *Approaches* team in January 2023, and the last three years have flown by. Working alongside Andeline, Giorgos and Lucy and being in contact with different authors, reviewers and readers has been a huge privilege. Thinking together about how to expand, shape and develop the journal further has been one of the most enjoyable aspects of this role. I have learned from each member of the editorial team and loved the open attitude and exploratory invitations to play together.

When I was invited to apply for the role of associate editor, I took each of the letters of the word APPROACHES and used these as tiny catalysts for statements about how I might see myself working with the team and what I thought I could bring. Looking back at this, my words – **Arts-based inquiry; Possibilities; Plus; Resonances; Open (access); Attitude; Creativity; Humour; Ethos; Supporting scholarship** – still offer a generative introduction to the role of *Approaches* in the field of music therapy and beyond, and more broadly offer points for reflection around what I think a journal can *do*.

As well as using this editorial to offer thanks to everyone I have worked with, my intention was to reflect a little on my time with *Approaches* and the role of being an associate editor. Through this process, I found myself revisiting ideas around our previous editorial (dos Santos et al., 2025) and thinking about questions well beyond my own role as associate editor with the journal.

KNOWING FLOW

In our arts-based exploration of thoughts and experiences of gatekeeping (dos Santos et al., 2025), the *Approaches* editors engaged in individual arts-based reflexive process. Collectively, these explorations led to threads which warrant further expansion. Re-reading Andeline dos Santos' reflections on her early sense of being a new researcher separated from a more experienced researcher by a flowing river struck me as particularly vivid. Understanding different levels of experience as points of pause whilst looking across an expanse of knowing flow seemed, to me, to capture my own sense

of knowing as an ever-emerging expansive process. Perhaps we do not just move between knowing and not knowing, jumping across the river as we come to know more, but move through knowing.

In their recent article, Lewsley et al., (2025) articulate a *feminist ethics of care* through their co-creative storytelling of the health of a section of the Dyarubbin river in Western Australia. Through narrative inquiry, they draw on their felt interactions with this river to trouble at experiences of “paternalistic, extractivist, and anthropocentric” (p. 525) ways of knowing that privilege normative temporalities and follow expected linearities in academic knowledge production. Engaging with the river in this way allowed them an embodied dialogue which moved beyond just a human knowledging and the river rivering. The authors’ communing with the river could be summed up by Donna Haraway’s (2016) idea of *sympoiesis*, or making-with.

KNOWING THROUGH FLOWING

Lewsley et al.’s (2025) point of departure was the question: ‘How are you going, river?’ I enjoyed this question and used it to catalyse an arts-based reflexive exploration of my own role as an associate editor over the last three years. I audio recorded a 6–7-minute solo improvisation using my violin and then drew freely while listening to the recording I had just made. Following this, I made some brief written reflections. I have referred to this elsewhere as *thinking through improvisation* (Haire, 2022). The drawing that emerged seemed to capture an expansive surge of watery energy. I have included a brief excerpt below along with the hand-drawn image.



*Repetition and bubbling-ness.
Images of water flowing over rocks.
Rapids, and changes in speed came
to me... There was a lot of movement
in my playing... less of a slow deep
river feel.... I think I was caught in a
stream.*

The riveriness of a river, to me, offers a generative notion of how knowing emerges and changes as time flows.

THE FLOW OF A JOURNAL

A dialogic ethos is something that drew me to apply for the role of an associate editor. The emphasis on critical reflexivity and dialogue is a strong aspect of my own work, and I know that many new authors, alongside more established researchers and practitioners, submit their work to *Approaches* precisely due to the strong support for knowing as an emergent and ongoing process. Along with this, being a diamond open access journal supports a non-exclusive stance and helps foster non-linear nature of knowing.

How are you going, journal?

It is not just the work of the editors to find a way to cross a river, or construct points of rest on the bank. At their most alive, journals exist *through* authorship and readership, positioned somewhere between, offering a throughway for the exchange of knowing. This position is necessarily responsive to context and weather, so to speak, perhaps somewhat like Haraway's (2016) idea of *response-ability*. In academic scholarship – such as that undertaken through *Approaches* – one could say that as a journal we are respons-able for taking care of a knowing flow.

FLOWING ON

Approaches is entering a period of transition as we move to a rolling publication model alongside changes in our editorial team as some colleagues move on and some colleagues join. This movement, whilst requiring considerable administrative organisation, also allows for a re-appraisal of how *Approaches* works and thinking around its ongoing development.

Being a part of the editorial team at *Approaches* has offered me many things regarding scholarship and inquiry. The catalysts I used to generate a statement of intent when applying for the role of associate editor would be the same if I applied for the role tomorrow.

I am sorry to leave, but also looking forward to re-establishing the flow of music therapy practice in my week. I feel excited about the reverberations of *Approaches Plus* and finding ways into the in-between and 'behind-the-scenes' aspects of scholarship that we have been working to find a home for. There are so many hidden experiences as part of inquiry and research that are often left out of the distilled version of events. The stories untold feel, to me, as interesting and important as the 'clean' version of events that usually remain and offers one way to know *with* an author through dialogue about their process.

Approaches continues to support the growth of a culture of inquiry and scholarship through its current sponsorship of the research talks at Queen Margaret University (QMU). Most recently, we welcomed Kat McFerran to QMU for a fascinating presentation about musical pleasure and treating anhedonia in music therapy. We are also very excited about our upcoming roundtable as a journal at the 18th World Congress of Music Therapy in Bologna: Bridges of recognition and epistemic justice: A dialogue with an open-access journal. I hope to see you there!

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ΣΗΜΕΙΩΜΑ ΣΥΝΤΑΞΗΣ

«Πώς πας, ποταμέ;» Περνώντας μαζί εποχές αλλαγών

Nicky Haire

Queen Margaret University, Ηνωμένο Βασίλειο

ΒΙΟΓΡΑΦΙΑ ΣΥΓΓΡΑΦΕΑ

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Ελληνική μετάφραση: Μίτσου Ακογιούνουλου

Ήταν χαρά μου να ενταχθώ στην ομάδα του *Approaches* τον Ιανουάριο του 2023, και τα τελευταία τρία χρόνια πέρασαν πολύ γρήγορα. Η συνεργασία μου με την Andeline, τον Γιώργο και τη Lucy, καθώς και η επικοινωνία με διαφορετικούς συγγραφείς, κριτές και αναγνώστες, αποτέλεσαν μεγάλη τιμή. Η κοινή μας σκέψη για το πώς να επεκτείνουμε, να διαμορφώσουμε και να αναπτύξουμε περαιτέρω το περιοδικό ήταν μία από τις πιο ευχάριστες πτυχές αυτής της θέσης. Έμαθα πολλά από το κάθε μέλος της συντακτικής ομάδας και μου άρεσε ιδιαίτερα η ανοιχτή διάθεση καθώς και οι διερευνητικές και παιγνιώδεις προσκλήσεις για συνεργασία.

Όταν με κάλεσαν να υποβάλω αίτηση για τη θέση της αναπληρώτριας συντάκτριας, πήρα κάθε ένα από τα γράμματα της λέξης APPROACHES και τα χρησιμοποίησα ως μικρούς καταλύτες για να δηλώσω το πώς φανταζόμουν τον εαυτό μου να συνεργάζεται με την ομάδα και τι πιστεύω ότι θα μπορούσα να προσφέρω. Κάνοντας μια αναδρομή, οι λέξεις μου – Arts-based inquiry (έρευνα βασισμένη στις τέχνες), Possibilities (δυνατότητες), Plus (συν), Resonances (αντηχήσεις), Open (access) (ανοικτή [πρόσβαση]), Attitude (στάση), Creativity (δημιουργικότητα), Humour (χιούμορ), Ethos (ήθος), Supporting scholarship (υποστήριξη της επιστημονικής ενασχόλησης) – εξακολουθούν να προσφέρουν μια δημιουργική εισαγωγή στον ρόλο του *Approaches* στο πεδίο της μουσικοθεραπείας και πέρα από αυτόν, και πιο ευρέως προσφέρουν σημεία για προβληματισμό σχετικά με το τι πιστεύω ότι ένα περιοδικό μπορεί να κάνει.

Εκτός από το να χρησιμοποιήσω αυτό το σημείωμα σύνταξης για να ευχαριστήσω όλους με τους οποίους συνεργάστηκα, η πρόθεσή μου ήταν να αναστοχαστώ λίγο πάνω στον χρόνο μου στο *Approaches* και στον ρόλο της αναπληρώτριας συντάκτριας. Μέσα από αυτή τη διαδικασία, βρέθηκα

να επανεξετάζω ιδέες γύρω από το προηγούμενο σημείωμα σύνταξής μας (dos Santos και συν., 2025) και να σκέφτομαι ερωτήματα πολύ πέρα από τον δικό μου ρόλο ως αναπληρώτριας συντάκτριας του περιοδικού.

ΓΝΩΡΙΖΟΝΤΑΣ ΤΗ ΡΟΗ

Στη βασισμένη στις τέχνες εξερεύνηση των σκέψεων και των εμπειριών της «θυροφύλαξης» (gatekeeping) (dos Santos και συν., 2025), οι συντάκτες του *Approaches* ασχοληθήκαμε με μια ατομική καλλιτεχνική αναστοχαστική διαδικασία. Συλλογικά, αυτές οι αναζητήσεις οδήγησαν σε νήματα σκέψης που χρήζουν περαιτέρω διερεύνησης. Ξαναδιαβάζοντας τους αναστοχασμούς της Andeline dos Santos αναφορικά με το αρχικό της αίσθημα ως μια νέα ερευνήτρια η οποία διαχωρίζεται από έναν πιο έμπειρο ερευνητή από ένα ποτάμι που κυλάει, με εντυπωσίασε η ζωντάνια της περιγραφής. Η κατανόηση των διαφορετικών επιπέδων εμπειρίας ως σημείων παύσης, ενώ ταυτόχρονα κοιτάζουμε απέναντι σε ένα πεδίο γνώσης που ρέει, φάνηκε, κατά τη γνώμη μου, να αιχμαλωτίζει τη δική μου αίσθηση της γνώσης ως μιας διαρκώς αναδυόμενης, διευρυνόμενης διαδικασίας. Πηδώντας πέρα από το ποτάμι καθώς αποκτούμε περισσότερη γνώση, ίσως δεν κινούμαστε απλώς μεταξύ του να γνωρίζουμε και του να μη γνωρίζουμε, αλλά κινούμαστε μέσα από τη γνώση.

Στο πρόσφατο άρθρο τους, οι Lewsley et al. (2025) αρθρώνουν μια *φεμινιστική ηθική της φροντίδας* μέσα από τη συν-δημιουργική τους αφήγηση της υγείας ενός τμήματος του ποταμού Dyarubbin στη Δυτική Αυστραλία. Μέσω αφηγηματικής έρευνας, αντλούν από τις βιωματικές αλληλεπιδράσεις τους με αυτόν τον ποταμό για να αμφισβητήσουν τις εμπειρίες των «πατερναλιστικών, εξαγωγικών και ανθρωποκεντρικών» (σ. 525) τρόπων γνώσης που ευνοούν κανονιστικές παροδικότητες και ακολουθούν αναμενόμενες γραμμικότητες στην παραγωγή ακαδημαϊκής γνώσης. Η αλληλεπίδραση τους με τον ποταμό με αυτόν τον τρόπο επέτρεψε έναν ενσώματο διάλογο που κινήθηκε πέρα από μια απλή ανθρώπινη γνώση και ποταμίσια ροή. Η κοινωνία των συγγραφέων με τον ποταμό θα μπορούσε να συνοψιστεί με την ιδέα της Donna Haraway (2016) για τη *συνποίηση*, ή τη συν-δημιουργία.

ΓΝΩΡΙΖΟΝΤΑΣ ΜΕΣΑ ΑΠΟ ΤΗ ΡΟΗ

Το σημείο εκκίνησης των Lewsley et al. (2025) ήταν η ερώτηση: «Πώς πας, ποταμέ;» Μου άρεσε αυτή η ερώτηση και τη χρησιμοποίησα ως καταλύτη για μια καλλιτεχνική αναστοχαστική εξερεύνηση του δικού μου ρόλου ως αναπληρώτριας συντάκτριας τα τελευταία τρία χρόνια. Ηχογράφησα έναν ατομικό αυτοσχεδιασμό 6-7 λεπτών χρησιμοποιώντας το βιολί μου και στη συνέχεια ζωγράφισα ελεύθερα ενώ άκουγα την ηχογράφηση που μόλις είχα κάνει. Στη συνέχεια, έγραφα κάποιους σύντομους αναστοχασμούς. Έχω αναφερθεί σε αυτό αλλού ως *σκέψη μέσω αυτοσχεδιασμού* (Haire, 2022). Το σχέδιο που προέκυψε φάνηκε να αποτυπώνει μια επεκτατική ορμή υδάτινης ενέργειας. Παρακάτω περιλαμβάνω ένα σύντομο απόσπασμα μαζί με τη χειρόγραφη εικόνα.



Επανάληψη και αίσθημα ζωντάνιας. Εικόνες νερού που κυλάει πάνω στα βράχια. Ορμητικά ρεύματα και αλλαγές στην ταχύτητα ήρθαν στο νου μου... Υπήρχε πολλή κίνηση στο παίξιμό μου... λιγότερο από μια αίσθηση ενός αργοκίνητου βαθύ ποταμού... Νομίζω ότι παρασύρθηκα από ένα ρεύμα.

Η αίσθηση της κίνησης του ποταμού, για μένα, προσφέρει μία δημιουργική ιδέα σχετικά το πώς η γνώση αναδύεται και μεταβάλλεται με τη ροή του χρόνου.

Η ΡΟΗ ΕΝΟΣ ΠΕΡΙΟΔΙΚΟΥ

Ένα διαλογικό ήθος είναι κάτι το οποίο με ώθησε να κάνω αίτηση για τη θέση της αναπληρώτριας συντάκτριας. Η έμφαση στην κριτική αναστοχαστικότητα και στον διάλογο είναι μία σημαντική πτυχή του έργου μου, και γνωρίζω ότι πολλοί νέοι συγγραφείς, αλλά και πιο έμπειροι ερευνητές και επαγγελματίες, υποβάλλουν τις εργασίες τους στο *Approaches* ακριβώς λόγω της ισχυρής υποστήριξης που δίνεται στη γνώση ως μια αναδυόμενη και συνεχιζόμενη διαδικασία. Παράλληλα, το γεγονός ότι είναι ένα περιοδικό διαμαντένιας ανοικτής πρόσβασης υποστηρίζει μια μη μονοπωλιακή θέση και συμβάλλει στην καλλιέργεια της μη γραμμικής φύσης της γνώσης.

Πώς πας, περιοδικό;

Δεν είναι μόνο έργο των συντακτών να βρουν έναν τρόπο να διασχίσουν έναν ποταμό ή να κατασκευάσουν σημεία ανάπαυσης στην όχθη. Στην πιο ζωντανή τους μορφή, τα περιοδικά υπάρχουν μέσω της συγγραφικής και της αναγνωστικής κοινότητας, τοποθετημένα κάπου ενδιάμεσα, προσφέροντας έναν δίαυλο για ανταλλαγή της γνώσης. Αυτή η θέση ανταποκρίνεται απαραίτητα στο πλαίσιο και στις συνθήκες, θα μπορούσε να πει κανείς, ίσως κάπως όπως η ιδέα της Haraway (2016) περί *ευθύνης ικανότητας-απόκρισης* (response-ability). Στην ακαδημαϊκή έρευνα – όπως αυτή που πραγματοποιείται μέσω του *Approaches* – θα μπορούσε να πει κανείς ότι ως περιοδικό είμαστε υπεύθυνοι και αποκρινόμαστε στη φροντίδα της ροής της γνώσης.

ΡΕΟΝΤΑΣ

Το *Approaches* εισέρχεται σε μια μεταβατική περίοδο, καθώς υιοθετούμε ένα μοντέλο κυλιόμενων δημοσιεύσεων, παράλληλα με αλλαγές στη σύνθεση της συντακτικής μας ομάδας, καθώς κάποιοι συνάδελφοι αποχωρούν και άλλοι προστίθενται. Αυτή η κίνηση, αν και απαιτεί σημαντική διοικητική

οργάνωση, επιτρέπει επίσης μια επανεκτίμηση του τρόπου λειτουργίας του *Approaches* και μια αναθεώρηση της συνεχιζόμενης ανάπτυξής του.

Η συμμετοχή μου στη συντακτική ομάδα του *Approaches* μου έχει προσφέρει πολλά σχετικά με την ακαδημαϊκή και ερευνητική μου πορεία. Οι καταλύτες που χρησιμοποίησα για τη δημιουργία μια δήλωσης πρόθεσης όταν υπέβαλα αίτηση για τη θέση της αναπληρώτριας συντάκτριας θα παρέμεναν οι ίδιοι αν έκανα αίτηση για τη θέση αύριο.

Λυπάμαι που φεύγω, αλλά ταυτόχρονα ανυπομονώ να επαναφέρω τη ροή της μουσικοθεραπευτικής πράξης στην εβδομάδα μου. Νιώθω ενθουσιασμό με την απήχηση του *Approaches Plus* και για τον τρόπο προσέγγισης των ενδιαμέσων και «παρασκηνιακών» πτυχών της επιστημονικής ενασχόλησης, για τις οποίες έχουμε προσπαθήσει να δημιουργήσουμε ένα «σπίτι». Υπάρχουν τόσες πολλές κρυφές εμπειρίες ως μέρος της έρευνας και της μελέτης που συχνά παραλείπονται από την στείρα εκδοχή των γεγονότων. Οι αφηγήσεις που δεν αρθρώνονται μου φαίνονται εξίσου ενδιαφέρουσες και σημαντικές με την «καθαρή» εκδοχή των γεγονότων που συνήθως παραμένει, και προσφέρουν έναν τρόπο να γνωρίσει κανείς με έναν συγγραφέα μέσω του διαλόγου για τη διαδικασία τους.

Το *Approaches* συνεχίζει να υποστηρίζει την καλλιέργεια μιας κουλτούρας έρευνας και επιστημονικής μελέτης μέσω της τρέχουσας χορηγίας των ερευνητικών διαλέξεων στο Queen Margaret University (QMU). Πρόσφατα, υποδεχθήκαμε την Kat McFerran στο QMU για μια συναρπαστική παρουσίαση σχετικά με τη μουσική ευχαρίστηση και τη θεραπεία της ανηδονίας στη μουσικοθεραπεία. Είμαστε επίσης πολύ ενθουσιασμένοι για την επερχόμενη στρογγυλή μας τράπεζα στο 18ο Παγκόσμιο Συνέδριο Μουσικοθεραπείας στη Μπολόνια με θέμα: «Γέφυρες αναγνώρισης και επιστημονικής δικαιοσύνης: Ένας διάλογος με ένα περιοδικό ανοικτής πρόσβασης». Ελπίζω να σας δω εκεί!

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ARTICLE

Identifying different states of music-facilitated relaxation

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ABSTRACT

Music-facilitated relaxation is commonly employed by professionals such as music therapists, as well as used recreationally by music listeners. According to the Russel's Circumplex model of affect, relaxation can be understood as a state of low arousal whilst Smith suggested that it includes a variety of positive affect states. The goal of this study was to explore how music listeners describe music-facilitated relaxation. The aims are to investigate 1) whether Smith's relaxation model can be applied to music-facilitated relaxation, and 2) what is the role of valence and arousal in music-facilitated relaxation. Data was collected using an online survey. 109 participants were asked to describe their experience of music-facilitated relaxation in an open-ended question. Based on Smith's relaxation model and circumplex model of affect, the data was analysed using mixed methods content analysis. Participants described states of both reduced arousal and increased arousal, as well as positive and negative valence. Smith's model could not be used to successfully identify all music-facilitated relaxation states. Based on the data and Smith's model, five main categories, comprising 15 states of music-facilitated relaxation, were identified: Mindful (36% of total relaxation descriptions), Restful (21%), Transcendental (21%), Fulfilment (16%), and Energetic (6%). These results suggest that music-facilitated relaxation cannot be understood a state of low energy and positive emotions but rather aimed at achieving an optimal state for a current activity and situation. The findings of this research can inform future research and practitioners when planning to use music for relaxation or assessing client's music use.

KEYWORDS

relaxation,
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BACKGROUND

Relaxation plays an important role in stress management, and it is one of the most common self-regulating processes that can be assisted by music listening (van Goethem & Sloboda, 2011). Music-facilitated relaxation is commonly used among professionals such as music therapists as well as individually by music listeners. In clinical settings, music-facilitated relaxation is typically used to reduce patients' arousal (e.g., Davis & Thaut, 1989; Robb, 2000; Staum & Brotons, 2000). Music can even be used directly to facilitate sleep and a meta-analysis revealed that music can have an overall moderate positive effect on sleep quality (De Niet et al., 2009). Music-facilitated relaxation can be approached as an affect regulating process (Saarikallio et al., 2017). However, researchers do not fully understand the mechanisms behind music-facilitated relaxation and the variety of ways it affects everyday music listeners. Smith (2007) proposed a relaxation model, arguing that relaxation is not one state, but rather an umbrella term for different states that vary from sleepy to energised. He proposed 19 relaxation states that can be divided into four groups: Basic relaxation, Positive energy, Core mindfulness and Transcendence. In comparison to the Circumplex model of affect (Russell, 1980), the states described in Smith's model mainly represent positive valence, but are notably more nuanced in their arousal content.

In addition to sleep, music-facilitated relaxation also helps with managing stress (e.g., Pelletier, 2004; de Witte et al., 2019). Although previous models explore the concept of relaxation from the researcher's perspective, these leave open the question of what relaxation entails for everyday music listeners. Creating more detailed knowledge on what musical relaxation is can also further our understanding of how music helps stress management. Before delving into the topic of using music for relaxation, we would like to discuss functions of music from a broader perspective. Functions of music have been the subject of music psychology research for the past few decades. Hargreaves and North (1999) concentrated on the social functions of music and proposed that social function is manifested in three principal ways: management of self-identity, interpersonal relationships, and mood. Later, Schäfer et al. (2013) proposed three dimensions of music functions: people use music to regulate arousal and mood, to achieve self-awareness, and as an expression of social relatedness. Van Goethem and Sloboda (2011) discussed music's role in broader affect regulation processes (e.g., distraction, introspection, active coping) as well as in creating happiness and relaxation. Saarikallio et al. (2019) observed that music-related pleasure is linked to experiences of either relaxation or connectedness. Groarke and Hogan (2016) highlight the role of music evoked strong emotions, reminiscence, and eudaimonic experiences that include meaning and transcendence, in adaptive music listening that enhances wellbeing.

The perception of emotions in music has been linked to gender, age, and culture related factors. Hofbauer and Rodriguez (2023) found that older participants reported higher positive emotional valence, whilst subjective arousal was positively linked to higher tempo and level of education. Habe et al. (2023) established that female participants experienced positive and negative effect more frequently, and used music more often in intrapersonal and social contexts than men. Functional organisation of the brain for music processing has been proposed as a neurological basis for gender differences (Koelsch et al., 2003; Wuttke-Linnemann et al., 2019) whilst cultural and social norms affecting personality traits have been suggested as a cause for psychological differences (Herrera et al., 2018; Sergeant & Himonides, 2014). Some authors argue that although factors such as age and gender have an effect on the personal experience of music listening, their effects are likely to be very small (Gabrielsson & Juslin, 1996, 2003; Juslin, 2005). This is supported by a study on relaxation in elderly Taiwanese people (Hui-Ling, 2004), which found that whilst music induced relaxation,

as shown by heart and respiratory rates and finger temperature of participants, there were no significant differences based on preferences or demographic variables.

The debate about prescribed and self-selected music for relaxation has a long history. While some authors favour “prescribed” relaxation music (Pelletier, 2004), other researchers (Davis & Thaut, 1989; Labbé et al., 2007; Yehuda, 2011) highlight the role of preference, familiarity, and the sense of control that are associated with self-selected music. While both approaches have their pros and cons, and are equally capable of achieving the desired states, the current trend in clinical practice acknowledges individual differences, which involves using self-selected music and understanding the effects of music from a constructivist perspective (Thaut & Davis, 1993). This aligns with the paradigm shift from stimulus-response approaches towards more constructivist approaches in research, which can be observed in general affective sciences (e.g., Feldman Barrett, 2017) as well as in research on music and emotion, of which emotional responses to music are understood as being embedded in our individual contexts and meanings (Lennie & Eerola, 2022).

In a previous study on adolescents’ music listening for relaxation (Minkkinen et al., 2022) some surprising results were observed. First, contrary to expectations, some participants felt more energetic after reporting successful relaxation with music. Second, no links were found between musical genres and relaxation response. Instead, the clearest predictor of a successful relaxation was a strong personal relationship with music. The current study was designed to explore the links between music and relaxation in a more in-depth manner. A variety of data was collected for this study, which was not included in this article, including music listening habits, music preferences (including examples), free descriptions of relaxation experiences, self-reported cognitive, emotional, and physical stressors, and various demographic information. The present article is the first step in systematically analysing a variety of variables that could contribute to music-facilitated relaxation. Since the verbal discourse is so rich and varied, we dedicate the present article to the analysis and classification of the participants’ descriptions of their experiences of music-facilitated relaxation.

Aims

The aim of the current study was to explore how music listeners describe music-facilitated relaxation. Emphasis was placed on how music listeners themselves define the experiences of music-facilitated relaxation. Smith’s relaxation model and the Circumplex model of affect were used as reference points for the mapping of experiences. The research questions were as follows:

1. Can Smith’s relaxation model be applied to the experiences of music-facilitated relaxation and if so, how?
2. How do the experiences of music-facilitated relaxation reflect the affective dimensions of valence and arousal according to the Circumplex model of affect?

Music-facilitated relaxation is a complex phenomenon that changes not only from person to person but also from day to day. As such, the decision was made not to ask participants to depict one specific example of music-facilitated relaxation, which could reflect differing needs and varying resource availability, but to ask for an ideal situation that would describe how a person would use music to relax if there were no limitations. This decision led to rich and varied descriptions of experiences that were not limited to the most frequent or available ways of utilising music in everyday life. With regard to the subject of the current article, a second decision was made to perform discourse analysis separately from the analysis of musical parameters and lyrics. It was felt that if researchers knew the musical and lyrical content associated with a particular description, this could

affect their analysis of the discourse. Subsequently, the current article is based on participants' experiences of music-facilitated relaxation, and a forthcoming article will compare how this information relates to (or contradicts) information retrieved from musical parameters or lyrics.

METHOD

Participants

Participants were recruited via an online survey, which was distributed via social media (Facebook) and mailing lists, inviting anyone who uses music to relax to participate (convenience sampling). All participants provided informed consent prior to answering the questions.

A total of 109 participants completed the survey. Fifty-nine of them were female (54%), 47 were male (43%) and 3 of other gender (3%). Participants were aged from 19 to 77 years old ($M = 35$, $SD = 3.19$), and they were from 17 different countries from Europe (Belgium, Germany, Greece, Finland, Latvia, Lithuania, Spain, Sweden, and the United Kingdom), from Asia (India, Israel, Russia, State of Qatar, Turkey), from North America (United States of America), from Australia (Australia) and from Africa (Kenya), while the majority ($n = 62$, 57%) were from Finland.

Procedure

The online survey consisted of a variety of qualitative and quantitative questions about participants' experiences of music-facilitated relaxation and demographics-related questions. The main question of the survey was:

Imagine that you are feeling as relaxed as possible whilst listening to music. Please describe, in as much detail as you can, where you are, what you are listening to, and what you are thinking and feeling. Are you humming, singing along or playing an instrument? Are you staying still, moving around, dancing or doing some other activity?

The aim of this question was to provide rich and comprehensive knowledge about how participants described their personal experiences of music-facilitated relaxation.

Data analysis

The data consisted of answers to the main open-ended question stated above and short answers or multiple-choice answers to demographic questions. Answers to the open-ended questions varied in length from extremely short like "Sitting relaxed" to a few paragraphs long. Most answers were, however, a few sentences long. Participants described real and imaginary situations of relaxation with music in different forms. The nature of descriptions was usually rather static: participants described the situations, their feelings and sensations from the here-and-now viewpoint, and descriptions of continuing processes were rare. For examples see "Describing five categories of music-facilitated relaxation" in the Results section.

Mixed-methods content analysis was conducted with a deductive-inductive approach. Smith's model was used as the first theoretical basis for categorising the content of the relaxation experiences, but new themes were also allowed to emerge based on descriptions. The second framework used as a reference point of our analysis was the Circumplex model of affect (Russel, 1980).

Analysis of relaxation states based on Smith's model

Step 1: Exploratory coding by author 2. At this stage, the data was coded using a data-driven approach to familiarise ourselves with the data, and to learn about its quality and main characteristics.

Step 2: Group discussions involving all authors in order to reach consensus on how to conduct further analysis. First, Smith described relaxation states in a brief and broad manner, thus the states were not clearly defined and differentiated, and the authors had different interpretations of his writing. Second, the authors had to agree on how exactly the data needed to fit to Smith's states. For example, if a described state was very close to one of Smith's states but was not an exact match, would it be coded as a completely new state or as a variation of Smith's state? Third, the authors debated on whether states should be mutually exclusive, and concluded that each description could have more than one state.

Step 3: Developing and defining codes by author 1 and author 2. At this stage, codes and definitions of the states were developed using a combination of Smith's model and exploratory coding. For example, when participants used the word "mindfulness" in the description, but described experiences of physical relaxation, the authors agreed not to code these descriptions under Smith's core mindfulness category. Instead, the authors agreed to code it to the category of basic relaxation based on implicit meaning. Definitions of states were based on descriptions provided by Smith and further developed when needed.

Step 4: Author 1 and author 2 coded all the descriptions independently from each other, using the definitions developed in Step 3. After independent coding was completed, the authors compared their coded documents and discussed the differences. When a mistake was identified in one of the coded documents, it was corrected. All the remaining differences in the coded documents were used to calculate the inter-rater reliability of the relaxation states.

Analysis based on the Circumplex model of affect was conducted in three steps:

Step 1: After completing the analysis of the states, author 1 and author 2 independently coded all the data a second time to assign two numerical values to each relaxation description. The first number identified valence (5-very positive, 4-slightly positive, 3-neutral, 2-slightly negative, 1-very negative), and the second identified arousal (5-very high, 4-slightly high, 3-neutral, 2-slightly low, 1-very low). After independent coding was completed, authors 1 and 2 checked the assigned valence and arousal values of each description together to check for mistakes. When a mistake was identified in one of the coded documents, it was corrected, but all the remaining differences were averaged for each description.

Step 2: The states coded according to Smith's model were integrated into the results of the Circumplex model. All the descriptions were sorted into relaxation states, and author 2 calculated descriptive statistics of each state's valence and arousal values.

Step 3: Each relaxation state was placed on a Valence-Arousal map. At this step, the numeric values for valence and arousal were converted from 1-5, as described in Step 1, into -2 to +2 for convenient visualisation.

RESULTS

The applicability of Smith’s states to music-facilitated relaxation

Initial coding revealed 17 music-facilitated relaxation states. Twelve of these corresponded with Smith’s model and fitted into one of the four groups he has described. Five states, on the other hand, did not directly correspond to any relaxation states described by Smith. These states include discharge of negative emotions (Discharge), Imagery, reflections-memories-fantasies (Reflecting), aesthetic appreciation (Aesthetic) and the feeling of Agency (see Table 1).

	State	Inter-rater reliability (%)	Definition
States identified by Smith			
Basic relaxation	Sleepy	100%	Falling asleep
	Disengaged	100%	Isolating from the outside world
	Physically relaxed	78%	Physical sensations of relaxation
	Mentally relaxed	44.5%	Absence of worry about current issues, calm down
	<i>Rested/Refreshed</i>	N/A	N/A
Core Mindfulness	Aware/focused/clear	45.5%	Concentrating on a task, being in a flow state
	Quiet	55.6%	Being here-and-now, not thinking
	Accepting	N/A	N/A
	<i>Innocent</i>	N/A	N/A
	<i>Centred</i>	N/A	N/A
	<i>Awakening</i>	N/A	N/A
Positive Energy	Joyful	80%	Experiencing strong positive emotions
	Optimistic	87.5%	Experiencing low intensity positive emotions
	<i>Energised</i>	100%	Enjoying music-related physical activities
	<i>Thankful/Loving</i>	100%	Experiencing feelings of gratitude and love

Transcendence	Prayerful/reverent	100%	Religious and spiritual experiences
	Timeless/boundless/infinite/at one	63%	Transcendental experience of being the part of something bigger
	Mystery	N/A	N/A
	<i>Awe and wonder</i>	N/A	N/A
New states			
	Reflection/memories/fantasies	90%	Remembering the past, reflecting, fantasising
	Imagery	100%	Visual or kinaesthetic imagery
	Discharge	100%	Releasing negative emotions and stress with music
	Agency	100%	Feeling in control of one's life
	Aesthetic	100%	Appreciating the beauty

Table 1: Relaxation states, their definitions and inter-rater reliability

Note: **Bolded** – empirically identified by Smith; *Italic* – theoretically identified by Smith

Inter-rater reliability analysis revealed that the states Mentally relaxed and Aware/Focused/Clear had the lowest inter-rater agreement, 44.5% and 45% respectively. Quiet had 55.6%, Timeless/Boundless/Infinite/At one had 63%, Physically relaxed had 78% and Joyful had 80% inter-rater agreement. The states Optimistic and Reflection/Memories/Fantasies had the highest inter-rater reliability at 87.5% and 90% respectively.

Valence and arousal of music-facilitated relaxation states

Authors 1 and 2 assessed valence and arousal of each relaxation description using the Circumplex model of affect. Table 2 shows descriptive statistics for the valence and arousal values for each individual state.

Figure 1 illustrates each states' valence and arousal values. The size of the circles indicates how prevalent the states were in our data (bigger circles - more common state). The most common states were Physically relaxed ($n = 18$), Mentally relaxed ($n = 18$), and Quiet ($n = 18$). However, there was a high percent of coding differences in states Mentally Relaxed (44.5%), moderately high in Quiet (55.6%) and moderate in Physically relaxed (78%). The least common states were Prayerful ($n = 1$), Agency ($n = 2$), and Energised ($n = 3$).

All of the states except for Discharge had positive mean valence. Both Energised and Discharge had similar high arousal levels (1 and 1.33), but differed in valence, where Discharge had negative valence (-0.38) and Energised positive (0.5). There was a cluster of states with high arousal and high positive valence: Thankful/Loving, Joyful and Prayerful/Reverent are very close to each other. Agency also had high positive valence but had higher mean arousal scores than the other three. Sleepy was the state with the lowest arousal, and the nearest state to it was Physically Relaxed, although the latter was much closer to the central large cluster of states. The remaining states have low positive arousal and either low negative or low positive valence. It seems that Imagery, Timeless/Boundless/Infinite/

	Valence <i>M</i>	Valence <i>SD</i>	Arousal <i>M</i>	Arousal <i>SD</i>	<i>n</i>
Sleepy	0.25	0.61	-2.00	0.00	6
Physically relaxed	0.44	0.62	-0.99	0.70	18
Disengaged	0.63	0.48	0.25	0.87	4
Mentally relaxed	0.39	0.70	-0.44	1.25	18
Aware	0.32	0.46	0.23	0.90	11
Quiet	0.28	0.57	-0.83	0.57	18
Agency	1.75	0.35	2.00	0.00	2
Joyful	1.75	0.54	0.45	0.93	10
Optimistic	1.03	0.69	0.03	1.19	16
Thankful	1.70	0.45	0.90	0.22	5
Energised	0.50	1.50	1.33	0.58	3
Prayerful	2.00	0.00	1.00	0.00	1
Timeless	0.75	0.89	-0.25	0.89	8
Aesthetic	0.75	0.76	-0.42	0.80	6
Reflection	0.75	0.75	0.25	0.72	10
Imagery	0.60	0.70	-0.15	1.06	10
Discharge	-0.38	1.49	1.00	0.71	4

Table 2: States' Valence and arousal mean, SD and total number of instances

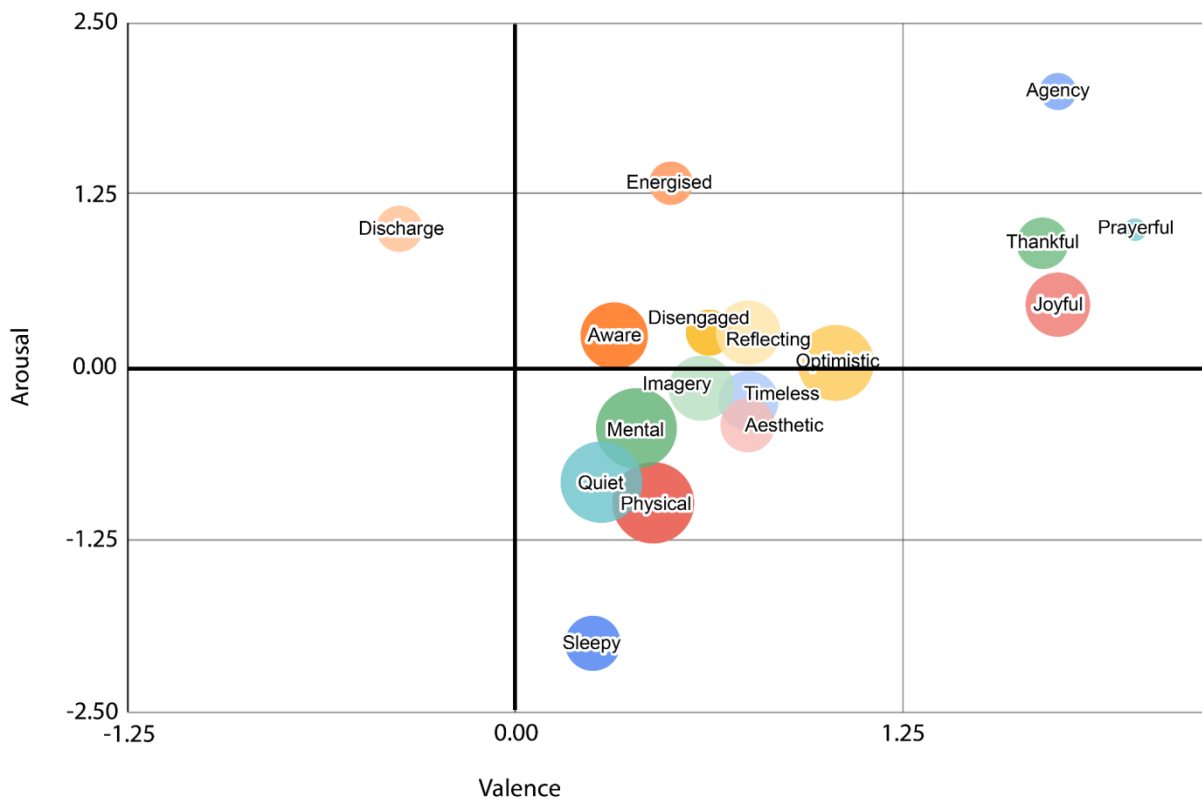


Figure 1: The states were mapped onto a Valence-Arousal map

Note: Mental - Mentally relaxed, Physical - Physically relaxed, Aware - Aware/Focused/Clear, Timeless - Timeless/Boundless/Infinite/At one, Thankful - Thankful/Loving, Prayerful - Prayerful/Reverent.

At one end Aesthetic are fairly close to each other, as well as Mentally relaxed, Quiet, and Physically relaxed, although the subgroups in the central cluster are less distinct from each other.

Identifying five categories of music-facilitated relaxation

There were three reasons why it was necessary to make adjustments to Smith's model for the purposes of describing music-facilitated relaxation (see Table 3). First, Smith's model includes exclusively positively valenced relaxation states, which were insufficient to describe our data since it included relaxation through the release of negative affect. Second, Smith's model does not include clear state definitions. As a consequence, a number of states had low inter-rater reliability due to conceptual overlap. Third, Smith grouped his states mostly on a theoretical basis, and we observed different clusters on the Valence-Arousal map. Consequently, the titles of the main categories were modified to reflect the conceptual change. Taking all of this into account, the results of this study can be summarised by five categories: Restful (21%), Energetic (6%), Mindful (36%), Fulfilment (16%), and Transcendental (21%). Restful relaxation refers to a state of resting, whether by tuning into the bodily sensations (Physical) or falling asleep (Sleepy). Energetic relaxation refers to the modulation of arousal, whether by increasing the energy levels (Energised) or releasing excess energy (Discharge). Mindful relaxation refers to states of thinking (Reflection), feeling (Optimistic), and being in the moment (Aware, Disengaged). Transcendental relaxation refers to altered states of consciousness, where one experiences loss of time (Timeless), beauty (Aesthetic), and spontaneous visuals (Imagery). Fulfilment relaxation refers to the sense of power (Agency), contentment (Thankful, Joyful), or spirituality (Prayerful).

Restful relaxation

State Sleepy. Using music to fall and stay asleep.

In bed trying to sleep, probably something like Sleeping At Last or There's A Light. Thinking about breathing and relaxing my body. I feel tired but warm inside. (P 64, F, amateur musician).

State Physically Relaxed. Experiencing physical sensations such as relaxing muscles, warmth, heaviness, and slow breathing.

I am laying down - Either in bed or a sofa etc, and I probably am at home or somewhere I feel safe and comfortable. My body feels relaxed - no tensions in muscles and the body feels "weighted" against the surface I am laying on. I am really still and my eyes are closed. (P 10, F, professional musician).

Energetic relaxation

State Discharge. Releasing negative emotions and stress.

If I'm annoyed/frustrated I choose something heavy and loud. (P 4, M, amateur musician).

State Energised. Enjoying physical activities such as dancing or working out.

When I want to be more in an upbeat or energetic mood, I listen and dance to EDM or house music in the private studio at my apartment gym to express how I'm feeling or simply have a good fun workout. (P 66, F, amateur musician).

Mindful relaxation

State Reflection. Remembering the past events, reflecting on one's life, lyrics of the song, etc., fantasising about the future. Includes reflection, memories, and fantasies.

I would be either in residence or a local bar joint, I would be listening to country music by legendary singers say, Kenny Rodgers, and I would be reflecting on the stories the singer would be telling. Since I don't usually memorize songs, I would be trying to sing along in parts though, while moving my head in line with the rhythm. (P 85, M, non-musician).

State Optimistic. Experiencing low intensity positive emotions such as feeling nice, good, peaceful.

I am in the bath, lying still with my eyes closed, listening to ambient music such as Brian Eno or Enya. I am feeling warm, cosy, safe and free. This feels like luxury time that I am making the most of. (P 11, F, professional musician).

State Aware. Being present in the moment such as concentrating on a task or simply not thinking or worrying about anything specific.

I am either at home or driving my car on a long stretch of familiar road. In both cases I am doing something time taking but monotonous: doing craftwork or art, for example, is more pleasant while listening to something. I may be singing along to familiar lyrics. Generally I listen to Spotify, my cds or occasionally my vinyls. If I am truly relaxed, I am not thinking of much else than the moment, as I am focused on the act of creation. (P 33, Other, professional musician).

State Disengaged. Isolating oneself from the outside world physically and mentally.

I am alone in the flat, I have headphones or earphones on - never listening to something worthwhile if someone else may hear it and either be disturbed in their day or disturb me in any way, so essentially I'm cutting myself off any outside world as much as possible, and not subjecting the outside world to my music as much as possible. Door of my room is locked. (P 50, F, non-musician).

Fulfilment relaxation

State Prayerful. Having religious and spiritual experiences.

[...] Worships, thinking about life and what it has to offer, feeling God's presence and being grateful, humming and singing along to the lyrics I know, moving around and equally doing some activities. (P 67, F, non-musician).

State Joyful. Experiencing strong positive emotions such as joy or happiness.

Sitting in stationary car with family listening to Michael Jackson music. We loved the music while travelling but it hadn't finished when we reached our

destination so we stayed in the car for greater enjoyment and to relax. Some members sang, I clapped and swayed to the music feeling happy. (P 47, F, non-musician).

State Thankful. Experiencing feelings of gratitude and love.

I love to play music while I dust my bedrooms and living rooms and I sing and think about my childhood. My mum is always in my thoughts as a lot of my music reminds me of her and her beautiful mind. (P 28, F, non-musician).

State Agency. Feeling in control of one's life, powerful, and capable.

In my small student apartment by myself, I am listening to national radio station, and I am singing all the parts I know as well as maybe dancing without thinking how I look. I am feeling like I am owning my own life and that I am independent. (P 49, F, non-musician).

Transcendental relaxation

State Timeless. Experiencing being a part of something bigger such as cosmos, nature, or music.

I'm lying in my bed and listening to slow music with low volume. Music takes me somewhere where I can't feel my body anymore; I just float without any strong emotions like sorrow, longing, excitement or happiness. I'm calm and I'm not thinking anything. My mind or soul is a part of Cosmos. (P 15, F, professional musician).

State Imagery. Experiencing visual and kinaesthetic imagery or synaesthesia.

I associate music with colours in my minds; relaxing music makes the colours very clear and I'm very emerged in them. I feel light and calm, like I'm floating on water or flying. I also feel inspired, my thoughts make sense and I can follow them easily. (P 40, F, non-musician).

State Aesthetic Appreciation. Appreciating the beauty of music or nature.

It is at home, I like high quality sound. There are two types of music: sentimental and energetic. While I'm listening sentimental music - I can feel beauty of the melody, fragility and it makes me feel elevated, calm. (P 43, F, professional musician).

Summarising five categories of music-facilitated relaxation

The music-facilitated relaxation experiences captured in our data included all Smith's proposed categories and an additional one (Table 3). Interpreting the five proposed categories within Smith's model would place Agency, Imagery, and Reflection within Core Mindfulness, whilst Aesthetic would fit within Transcendence. Discharge could not be placed within the existing Smith's model, because of its high negative valence.

Category	State	Link to Smith's model of relaxation
Restful relaxation	Physical	Smith's Basic Relaxation state
	Sleepy	Smith's Basic Relaxation state
Energetic relaxation	Energised	Smith's Positive Energy state
	Discharge	New state
Mindful relaxation	Aware	Smith's Core Mindfulness state
	Disengaged	Smith's Basic Relaxation state
	Optimistic	Smith's Positive Energy state
	Reflection	New state
Fulfilment relaxation	Agency	New state
	Joyful	Smith's Positive Energy state
	Prayerful	Smith's Transcendence state
	Thankful	Smith's Positive Energy state
Transcendental relaxation	Aesthetic	New state
	Imagery	New state
	Timeless	Smith's Transcendence state

Table 3: Five categories of music facilitated relaxation and their link to Smith's model

The most prevalent music-facilitated relaxation category was Mindful and the least common was Energetic (Table 4). When comparing the five relaxation categories to each other with regards to the Circumplex model of affect, the most positive was Fulfilment and the least positive was Energetic categories, while the category with the highest arousal was Energetic and the lowest arousal was Restful.

	Restful	Energetic	Mindful	Fulfilment	Transcendental
Valence <i>M</i>	0.35	0.06	0.68	1.80	0.70
Valence <i>SD</i>	-1.50	1.17	0.19	1.09	-0.27
Arousal <i>M</i>	0.62	1.50	0.60	0.34	0.78
Arousal <i>SD</i>	0.35	0.65	0.92	0.29	0.92
<i>n</i>	24	7	41	18	24

Table 4: Valence and arousal of five categories of music-facilitated relaxation

DISCUSSION

When talking about relaxation, participants often described a wide variety of states varying in valence and arousal. This suggests that music-facilitated relaxation cannot be understood purely through reduced arousal and positive valence but is a broader self-regulatory process. Our findings confirm the complexity of this phenomenon and stress the necessity of trying to understand the nuanced nature of it. Based on our findings we suggest that “relaxation” could be used rather as an umbrella term, and when possible, more specific terms for specific relaxation states could be used.

One of the main goals of this paper was to examine if Smith’s model (2007) could be successfully applied to music-facilitated relaxation. Out of the 19 states in Smith’s model, we found 12 states in our data. However, our results showed that Smith’s model was not specific enough, and we had to clarify and extend it by adding 5 novel states of music-facilitated relaxation. In total, we identified 15 music-facilitated states of relaxation that could be organised into five categories. The biggest limitation of Smith’s relaxation model, with regards to its applicability to music-facilitated relaxation, was that it only identifies positive relaxation states, while our analysis identified the Discharge state which had negative affect.

To sum up our findings, Mindful relaxation (36%) refers to states of thinking (Reflection), feeling (Optimistic), and being in the moment (Aware, Disengaged). Restful relaxation (21%) refers to a state of resting, whether by tuning into the bodily sensations (Physical) or falling asleep (Sleepy). Transcendental relaxation (21%) refers to altered states of consciousness, where one experiences loss of time (Timeless), beauty (Aesthetic), and spontaneous visuals (Imagery). Fulfilment relaxation (16%) refers to the sense of power (Agency) and contentment (Thankful, Joyful) or spirituality (Prayerful). Energetic relaxation (6%) refers to the modulation of arousal, whether by increasing the energy levels (Energised) or releasing excess energy (Discharge).

A question arises from our findings: if the music-facilitated relaxation is so nuanced, and if arousal is not the main element in it, what is the defining characteristic for all these relaxation states? Luberto et al. (2020), addressed the multiplicity of relaxation forms in the following way: “Relaxation can also be elicited during everyday activities. Any activity during which individuals maintain undivided attention and experience parasympathetic dominance can be considered a relaxation practice, and these likely vary across individuals” (Relaxation Practices section, para.2). This view offers some explanation for the multiplicity of relaxation states, but it only takes into account states with parasympathetic dominance. Parasympathetic dominance is traditionally associated with relaxation, but some states like Energetic and Discharge include sympathetic activation.

Another common element mentioned in the definition of relaxation is tension (American Psychological Association Dictionary of Psychology, n.d.). Perceived tension might potentially be a more suitable candidate for the role of a unifying element for music-facilitated relaxation. However, some participants described very intense experiences when talking about music-facilitated relaxation (e.g., of being connected to God, intense imagery and reflection upon one’s life). It is also worth noting that tension is sometimes understood as one of the dimensions of arousal, along with energy arousal (Thayer, 1989).

Perhaps the most realistic interpretation of the multiplicity of the relaxation states is that relaxation is a broader self-regulatory process: instead of always aiming for arousal or tension reduction, participants used music to regulate themselves to an optimal state for a current situation or activity.

The interpretation can be also approached from the viewpoint of music functions. Participants’ descriptions of their use of music for relaxation included different elements such as emotion

regulation, social, or transcendental. Traditionally in music research literature, these elements are described as separate music functions (Groarke & Hogan, 2016; Hargreaves & North, 1999; Schäfer et al., 2013; Van Goethem & Sloboda, 2011). One possible explanation might be that music is so embedded in our everyday lives, which creates a sort of inflation. When music is everywhere, it might become difficult for people to differentiate between different music use reasons and function, and the borders between some of them dissipate.

Limitations

This study is exploratory in its nature and is based on a fairly small sample. For example, the Energetic category is comprised of only seven descriptions, which is not sufficient to perform statistical comparison between different categories. More data needs to be collected in order to assess age, gender, and geographical location as factors in music-facilitated relaxation.

In our survey, participants were asked to imagine a scenario where they were relaxed while listening to music. The wording of the question was broad, to encourage a variety of experiences. Although the prompt generated a wide variety of descriptions, as was intended at this exploratory stage, some participants might have described a memory while others might have described a fictional situation. Future research should further investigate differences between ideal and practical situations, and the effect of the environment and other contextual factors on music-facilitated relaxation.

Smith's model (2007) lacks detailed descriptions of relaxation states which makes it difficult to apply them practically. We had group discussions to aid the development of our interpretation of Smith's model and created our own definitions of each state. This process led to a shared and consistent understanding of relaxation states, but we have no way of verifying whether they may differ from Smith's original ideas.

Some of the presented states are more commonly known in the music psychology literature as strategies or processes, e.g., Discharge (Saarikallio & Erkkilä, 2007). However, in this paper we chose to use the term "states" due to the nature of our data: participants' responses provided us with "snapshots" of experiences so the picture is rather static, and thus we considered "state" as a more appropriate term in this situation. So, we acknowledge that although we are presenting these phenomena as states, in reality some of these relaxation experiences also have a procedural nature.

CONCLUSION

Our results suggest that music-facilitated relaxation cannot be understood purely through reduced arousal or increased positive affect but is, rather, a broader self-regulatory process aimed at achieving an optimal state for a current situation. Although Smith's model of relaxation was not sufficient to fully explain all the variability in our data, it provided a good foundation for differentiating music-facilitated relaxation states. The next step in our research is to compare participants' descriptions as defined in this article with music analysis of their relaxation music selection and also participants' emotional, cognitive, and physical state. We hope that this exploratory study will provide the basis for larger studies that will investigate the factors contributing to this complex phenomenon.

In addition to its scientific impact, the findings of this research can inform practitioners when planning to use music for relaxation or assessing client's music use. First of all, it is important to better understand the challenges related to promoting relaxation as a part of stress management strategy. When developing and applying interventions that include music-facilitated relaxation, we

need to take into account the multiplicity of relaxation states and a person's preference towards some of these. When assessing one's stress management strategies and relaxation skills, we need to make sure that our understanding of relaxation aligns with the client's understanding, so that our understanding of the coping repertoire is adequate and our efforts to improve relaxation-based interventions are relevant. Finally, although this study focused on music-facilitated relaxation specifically, some of our results may be applicable for understanding relaxation in other contexts too, such as those combined with other creative activities.

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Ελληνική περίληψη | Greek abstract

Προσδιορισμός διαφορετικών καταστάσεων μουσικά-υποστηριζόμενης χαλάρωσης

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ΠΕΡΙΛΗΨΗ

Η μουσικά-υποβοηθούμενη χαλάρωση χρησιμοποιείται ευρέως από επαγγελματίες όπως οι μουσικοθεραπευτές, αλλά και από ακροατές μουσικής ως ψυχαγωγία. Σύμφωνα με το Κυκλικό μοντέλο (Circumplex) του Russel για το συναίσθημα, η χαλάρωση μπορεί να κατανοηθεί ως μια κατάσταση χαμηλής διέγερσης, ενώ ο Smith πρότεινε ότι περιλαμβάνει μια ποικιλία θετικών συναισθηματικών καταστάσεων. Σκοπός της παρούσας μελέτης ήταν να διερευνήσει πως οι μουσικοί ακροατές περιγράφουν την μουσικά-υποβοηθούμενη χαλάρωση. Οι στόχοι ήταν να εξεταστούν, 1) αν το μοντέλο χαλάρωσης του Smith μπορεί να εφαρμοστεί στη μουσικά-υποβοηθούμενη χαλάρωση, και 2) ποιος είναι ο ρόλος της συναισθηματικής φόρτισης και της διέγερσης στη μουσικά-υποβοηθούμενη χαλάρωση. Η συλλογή δεδομένων έγινε με τη χρήση ενός ηλεκτρονικού ερωτηματολογίου. Ζητήθηκε σε 109 συμμετέχοντες να περιγράψουν την εμπειρία της μουσικά-υποβοηθούμενης χαλάρωσης σε μία ερώτηση ανοιχτού τύπου. Βάσει του μοντέλου χαλάρωσης και του Κυκλικού μοντέλου συναισθημάτων του Smith, τα δεδομένα αναλύθηκαν με τη χρήση μικτής μεθόδου ανάλυσης περιεχομένου. Οι συμμετέχοντες περιέγραψαν καταστάσεις αποφόρτισης και αυξημένης διέγερσης, καθώς θετική και αρνητική συναισθηματική φόρτιση. Το μοντέλο του Smith δεν μπορούσε να χρησιμοποιηθεί για τον επιτυχή εντοπισμό όλων των καταστάσεων χαλάρωσης που διευκολύνονται από τη μουσική. Με βάση τα δεδομένα και το μοντέλο του Smith, αναδύθηκαν πέντε βασικές κατηγορίες, αποτελούμενες από 15 καταστάσεις της μουσικά-υποβοηθούμενης χαλάρωσης: Ενσυνειδητότητα (36% του συνόλου των περιγραφών χαλάρωσης), Ανάπαυση (21%), Υπερβατικότητα (21%), Πληρότητα (16%) και Ενεργητικότητα (6%). Τα αποτελέσματα αυτά υποδηλώνουν ότι η χαλάρωση με τη βοήθεια της μουσικής δεν μπορεί να θεωρηθεί μια κατάσταση χαμηλής ενέργειας και θετικών συναισθημάτων, αλλά μάλλον αποσκοπεί στην επίτευξη μιας βέλτιστης κατάστασης για μια τρέχουσα δραστηριότητα και κατάσταση. Τα ευρήματα αυτής της έρευνας μπορούν να ενημερώσουν τη μελλοντική έρευνα και τους επαγγελματίες όταν σχεδιάζουν τη χρήση μουσικής για χαλάρωση ή αξιολογούν τη χρήση μουσικής από τους πελάτες.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

χαλάρωση, μουσικά-υποβοηθούμενη χαλάρωση, αυτορρύθμιση, διέγερση, ένταση

ARTICLE

Finding common ground: Exploring speech language pathologists' experiences of collaboration with music therapists in treating people living with aphasia

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ABSTRACT

The purpose of this phenomenological study was to investigate speech-language pathologists' (SLPs') experiences of collaboration with music therapists (MTs) in treating people with aphasia. Our analysis of the data yielded mixed outcomes, highlighting/identifying aspects that support and challenge collaboration. Data was collected using semi-structured interviews with three participants. The participants were SLPs who had experience treating people with aphasia in hospital and community-based settings. Thematic analysis was used to identify components of MT-SLP collaborations in treating aphasia. Results revealed the following themes: personal and clinical aspects, and systemic challenges of MT-SLP collaborations. Participants' feedback on the thematic analysis was incorporated into the discussion which presents insights into the overarching qualities of successful MT-SLP collaboration and the contributions of music in aphasia treatment. This research provides a list of music interventions which may be a resource for SLPs and MTs in treating aphasia. Additionally, topics discussed in this research may assist SLPs and MTs in advocating for collaborative care of people living with aphasia.

KEYWORDS

phenomenology,
music therapy,
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INTRODUCTION

The purpose of this study was to investigate speech-language pathologists' experiences in collaborating with music therapists (MTs) and incorporating music into aphasia treatment. The motivation for choosing this topic comes from my¹ internship experience of collaborating with a

¹ In this study, the first person is used in reference to Author 1, who was the principal researcher in this study.

speech-language pathologist in facilitating online group music therapy sessions for adults with various types of aphasia. I enjoyed this collaboration and learned a great deal in the process. I was curious to know more about interdisciplinary collaborations and the impact of collaborative care on those involved. This research was conducted as part of the academic requirements for my programme of study under the supervision of Heidi Ahonen (Author 2). Ethics approval for this study was granted by Wilfrid Laurier University's Research and Ethics Board (REB #8410).

Speech-Language Pathology is a well-established allied-healthcare profession which focuses on assessing and treating various barriers to communication. The terms speech-language pathologist, speech-language therapist, and speech therapist are often used interchangeably. For the purposes of this study, the term speech-language pathologist (SLP) will be used for consistency. Speech-language pathology is the most common therapeutic modality involved in treating aphasia (John Hopkins Medicine, 2024). SLPs are trained to address communication challenges in the following treatment domains: speech, language, social communication, and cognitive communication (American Speech-Language-Hearing Association, n.d.).

Phenomenological inquiry was used to explore the following research questions:

1. What are SLPs' experiences of interdisciplinary collaboration in treating aphasia?
 - a. What are SLP's experiences in collaborating with music therapists?
2. What are SLP's perceptions of the impact of music in treating aphasia?
 - a. What are the perceived benefits of using music in aphasia treatment?
 - b. What are the perceived limitations of using music in aphasia treatment?
3. What are the practical aspects of MT-SLP interdisciplinary collaboration in treating aphasia?
4. What music therapy interventions use speech therapy ideas?

BACKGROUND INFORMATION

Aphasia is a language disorder which impairs the ability to communicate with others (Johns Hopkins Medicine, 2024). Aphasia is indicative of damage to the language-dominant left hemisphere of the brain, typically caused by stroke, head injury, brain tumour, infection, or dementia (Johns Hopkins Medicine, 2024; National Library of Medicine, 2022). Different types of aphasia such as Broca's aphasia, Wernicke aphasia, and Global aphasia can be delineated, based on the extent and location of the damage to the brain. Primary progressive aphasia (PPA) is a degenerative form of aphasia considered to be a "type of frontotemporal dementia" (Mayo Clinic Staff, 2023). Diagnosis of aphasia typically involves neuroimaging of the brain and an SLP assessment. Communication is integral to everyday life; as such, aphasia can have a devastating impact on the human connection, resulting in loss of self-esteem and social isolation. It is important to note that aphasia typically does not impair an individual's inherent competence but rather conceals it (Aphasia Institute, n.d.).

A SLP adopts a variety of approaches in treating aphasia, depending on the assessment and the extent of language impairment. The Life Participation Approach to Aphasia (LPAA) is a social model of aphasia care which focuses on re-establishing meaningful participation in life (Chapey et al., 2000; Holland, & Elman, 2020). The LPAA is a holistic approach to aphasia care which enables clients to

actively participate in their recovery. Clients are encouraged to collaborate with their SLP in decision-making regarding their treatment goals and interventions.

Music therapy encompasses a myriad of diverse orientations, approaches, methods, and models (McFerran et al., 2023). Music therapy practice is a fluid and dynamic process involving the intentional use of music therapy interventions within a therapeutic relationship. The choices surrounding the approach and methods of treatment are informed by external and individual contextual factors – for example, culture, clinical setting, diagnosis, and client preferences and strengths. Taking into account these factors, this enables music therapists to provide care tailored to the unique needs of each client. Music psychotherapy typically focuses on addressing psychosocial issues presented by the client (Kim, 2016). Music psychotherapists may assume an eclectic approach in therapy, incorporating elements from psychodynamic, humanistic, behavioural, cognitive, and systems-based orientations. Psychodynamic concepts such as transference and countertransference within a therapeutic relationship are integral to most music psychotherapy approaches.

The value of counselling in aphasia treatment is being explored in relation to addressing co-morbid mental health concerns such as mood disorders and social isolation (Sekhon et al., 2022). In Canada, professional title regulation for counselling and psychotherapy varies from province to province. The Canadian Counselling and Psychotherapy Association (CCPA) offers a nationwide definition for numerous counselling professions and psychotherapy noting that these related practices involve an interpersonal process offered by a skilled professional to effect positive change (CCPA, 2024). Although there is considerable overlap between these professions, psychotherapy training and scope of practice enables registered psychotherapists to use specialised interventions to treat individuals with chronic or severe mental health issues. In contrast, counselling may focus on supporting individuals through challenges of everyday life.

Psychotherapy which primarily involves speech as a means for expression may be less accessible to people with aphasia due to the nature of their impairment. Music psychotherapy offers clients opportunities for social interaction and self-expression through the thoughtful use of music (Kim, 2016). More research may be beneficial in clarifying the role that music psychotherapy can play in treating aphasia.

LITERATURE REVIEW

Literature exploring various aspects of music and aphasia care was examined to provide context for this research. Articles were selected from communication and rehabilitation focused journals in accordance with the purpose of the research. Relevant themes identified in the research included: types of interventions and treatment protocols, rationales for music-based aphasia treatment, and the application of research to clinical practice.

Interventions and treatment protocols

Most articles discussed discipline-specific treatment protocols for aphasia (i.e., SLP or MT). An exception to this was the research of Hurkmans et al. (2015), which focused specifically on Speech-

Music Therapy for Aphasia (SMTA). Musical interventions involving singing or vocal production were prevalent in the literature. These included Melodic Intonation Therapy (MIT; Curtis et al., 2020; Liu et al., 2022; Merrett et al., 2019), choral singing (Fogg-Rogers et al., 2016; Tamplin et al., 2013; Zumbansen et al., 2017), individual singing and/or vocalizing (Kasdan & Kiran, 2018) and songwriting (Mantie-Kozlowski et al., 2021). Other music interventions included instrument playing to address goals in the cognitive and motor domains (Magee et al., 2017) and phrase completion using recorded music (Chiapetta et al. 2022; Faroqi-Shah et al., 2020).

Rationale for music-based aphasia treatment

Research suggests that music-based interventions can target multiple treatment domains for people living with aphasia. This suggests that music may be a valuable medium for treating people with aphasia. Hurkmans' (2020) investigation of the treatment of aphasia and co-morbid motor-speech disorders (MSDs) suggests a possible motor-based mechanism underlying music-based interventions for aphasia. Music therapy interventions have also been shown to positively impact aspects of language recovery, such as naming and repetition of words and phrases (Liu et al., 2022). Kasdan and Kiran (2018) suggest that melody appears to aid word production and may serve as a helpful tool in language recovery. Music therapy has been shown to have a positive impact on functional communication, also referred to as everyday communication (Fogg-Rogers et al., 2016; Hurkmans et al., 2015; Liu et al., 2022). Research also suggests a potentially mitigative effect of musical training on linguistic syntactic processing in adults with aphasia (Chiapetta et al., 2022; Faroqi-Shah et al., 2020). Faroqi-Shah et al. (2020) suggest that musical training may mitigate the effects of aphasia by increasing the potential for neuroplasticity.

Psychosocial well-being is considered an important goal of aphasia rehabilitation due to the susceptibility of people with communication disorders to develop mood disorders (Chapey et al., 2000; Sekhon et al., 2022). Music-based intervention in aphasia treatment is characterised as a valuable tool for increasing social interaction, coping skills, and mood (Fogg-Rogers et al., 2016). Music therapy is also described as effective in improving "psychosocial outcomes in aphasia patients after stroke" (Liu et al., 2022, p.870). Additionally, therapeutic songwriting resulted in an improved quality of relationships for an individual with PPA (Mantie-Kozlowski et al., 2021). Auclair-Ouellet et al. (2022) discuss an Intensive Comprehensive Aphasia Program (ICAP), a non-musical treatment protocol focused on investigating the effects of intensity (i.e., frequency and dosage) on language, functional communication, emotional well-being, and quality of life in people with aphasia. In contrast to music-based interventions described above, the ICAP had no significant impact on the participants' "emotional well-being [and] quality of life" (Auclair-Ouellet et al., 2022, p. 1312).

Connecting research with clinical work

Merrett et al. (2019) discuss the challenges in researching the operational principles and effectiveness of standardised treatment protocols such as MIT. They highlight the contradictory approaches of therapeutic clinical work and efficacy-based research, noting that clinical work is often client-focused and requires in-the-moment adaptability. In contrast, efficacy-based research focuses on "standardization, generalizability" and "statistically sound evidence" (Merrett et al., 2019, p. 429).

A lack of agreement about outcome measures was identified in the literature. This was described as a confounding factor in studies which evaluate the efficacy of treatments (Auclair-Ouellet et al., 2022).

Additionally, Fogg-Rogers (2016) observe a lack of concurrence regarding a mode for comparison between qualitative and quantitative aphasia research. They observe that this creates difficulty when comparing qualitative and quantitative findings. The literature highlights the need for exploring how to connect research to clinical work and determine best treatment practices. Developing and refining outcome measures for aphasia treatment and standards of comparison between diverse research methodologies may play an important role in this endeavour.

Summary of the literature

Research exploring collaborative MT-SLP treatment of aphasia was limited in the literature reviewed. Hurkmans et al.'s (2015) research showed positive outcomes for client's receiving collaborative MT-SLP care (SMTA) which suggests that more research focusing on collaborative treatment of aphasia is warranted. Benefits of music intervention were present across multiple aphasia treatment domains including motor aspects of speech, communication, and psychosocial well-being. The impact of music based interventions on psychosocial well-being is significant due to the prevalence of comorbid mood disorders and psychosocial distress experienced by people with aphasia (Sekhon et al., 2022). Moreover, an intensive non-musical treatment protocol focusing on language and communication was shown to have limited impact on improving psychosocial well-being in people with aphasia (Auclair-Ouellet et al., 2022). However, this finding should be interpreted with care, as some non-musical aphasia treatment approaches such as the LPAA do account for the importance of psychosocial well-being in aphasia care (Chapey et al., 2000).

A notable finding of this literature review was the challenge of connecting research with clinical work. (Merrett et al., 2019). This challenge was attributed to the contradictory natures of research and clinical work and exposes an opportunity for research which aims to find common ground between these contrasting elements of aphasia care. This study aims to address this challenge by gaining insights from SLPs perspectives regarding challenges faced in their clinical work and opportunities for growth within their profession.

METHODOLOGY

The purpose of this study was to investigate SLPs' experiences in collaborating with MTs and incorporating music into aphasia treatment. Phenomenological inquiry was chosen for this study because it focuses on both the lived experience of a phenomenon and its meaning (Van Manen, 1997). Phenomenological inquiry recognises the subjective aspect of human experience and offers a means to consider and amalgamate multiple perceptions of a phenomenon (Jackson, 2016). Researchers combine a variety of methods and techniques to illuminate and describe the defining qualities of a phenomenon and formulate an interpretation of the data in response to the research questions. This encourages the researcher to be creative, reflective, and flexible during the research process, as they consider and incorporate new information as it arises (Jackson, 2016). A technique integral to all variations of phenomenological inquiry is "bracketing" (Jackson, 2016, p. 710)

Bracketing, also referred to as *epoche*, requires the researcher to intentionally identify and suspend their biases and preconceptions surrounding the phenomenon. This process enables the researcher to be receptive to all aspects of the data gathered and adopt a holistic understanding of the phenomenon.

My experience of collaborating with an SLP in treating aphasia was integral to the motivation for conducting this research. I perceived this experience to be enjoyable, engaging, and a valuable learning opportunity. I also carried the assumption that it was an overall positive experience for the SLP and clients. It was important that I considered these perceptions and assumptions through a reflexive approach in order to be fully open to the data which may include differing experiences of collaboration.

METHODS AND TECHNIQUES

This study explores topics such as music therapists' scope of practice, perceived benefits of incorporating music into aphasia treatment, perceived strengths and challenges within speech-language pathology's scope of practice, frameworks used for understanding communication, and challenges experienced in initiating interdisciplinary collaborations. Through discussion with my supervisor and consideration of the methodology, semi-structured interviews and thematic analysis were determined to be appropriate methods for exploring these topics. In accordance with these methods, individual participant interview findings are presented separately, followed by the thematic analysis of the collated interview data. Methods and techniques used in each step of the research will be discussed in further detail below.

Participant recruitment

This study used criterion-based purposive sampling (Jackson, 2016). Three participants were selected based on the following inclusion criteria:

1. 18 years or older
2. Accredited SLPs
3. Have experience treating aphasia in group and/or individual settings
4. Have collaborated with a music therapist before OR have interest in collaborating with a music therapist.
5. Proficient in English

Participants were recruited by emailing an advertisement to relevant professional and personal contacts, and the National Aphasia Association. Recipients were encouraged to share the notice among their own contacts. Item 4 on the inclusion criteria initially read, "have collaborated with a music therapist before." This was modified to accelerate initially slow recruitment. Modifying this inclusion criterion also provided a variety of participant perspectives. Three participants were recruited for this small-scale student research project. The participants were required to sign a consent document informing them of the potential benefits and risks of participation in the research.

Data collection

Data was collected using individual semi-structured interviews, conducted and recorded via the video conferencing platform Zoom. Interviews were one hour in length and scheduled at the participants' convenience. This data collection method was chosen to afford the interviewer flexibility during the interview process and encourage the collection of detailed and comprehensive data which reliably represents the participants' experiences (Jackson, 2016). An interview guide with suggested questions was used as a reference by the interviewer (Appendix A).

Data analysis and interpretation

Data was analysed using the techniques and process of thematic analysis, described by Braun and Clarke (2006, 2022). I adopted an inductive approach, where identification of themes was reliant on the contents of the data. Interviews were transcribed and read multiple times to allow for ample familiarisation with the data. Manual coding was used throughout the process to extract codes and generate, review, and refine themes. Data analysis occurred in two main phases: analysis of individual participant interviews and thematic analysis of all interviews. The overall process was iterative and involved ongoing engagement with the data resulting in a fluid process of coding and recoding, and proposing, refining, and defining themes.

The findings were summarised and shared with participants. Participants were asked to review and comment on the results in either a written questionnaire or a second semi-structured interview (Appendix B). This choice was offered to accommodate the participants' schedules and preferences. This process provided additional data and increased the trustworthiness of the results (Abrams, 2016). Two participants chose to share their comments on the results in a semi-structured interview conducted via Zoom. These conversations were not recorded, but detailed notes were taken. The remaining participant provided feedback via the questionnaire (Appendix B). Individual participant results are presented as a descriptive summary of the data collection interview. Overall results are presented in the format of themes and descriptive sub-themes.

Ethics

This research posed low risk to participants. Ethical considerations included the right to dignity and respect, the right to privacy and protection of personal information, and informed consent. Additionally, there was potential social risk for participants, namely, inadvertent identification by members of their professional community due to relevant contextual information in the research report. Participants were informed of this risk prior to participation and their right to withdraw consent at any time during the research process. Participants were also offered a chance to read the research report and be consulted regarding the inclusion of direct quotes and personal contextual information. This research project was approved by Wilfrid Laurier university's Research and Ethics Board (REB #8410).

FINDINGS

All three participants were SLPs experienced in working with people with aphasia. Two had previous experience collaborating with MTs. The third had no experience collaborating with an MT, but indicated interest in this. Their prior experience in collaborating with dieticians and occupational therapists indicated their general interest in interdisciplinary collaboration.

Participant 1

In discussing their path toward becoming an SLP, participant 1 (P1) described having the opportunity to observe a “vibrant” speech-pathology student as being instrumental in their choice to pursue this career. They indicated that their interest in “sociological framework[s] of participation” and communication, as well as Luria’s neuropsychological approach to rehabilitation supported their interest in working in aphasia treatment (Akhutina, 2015; Mikadze et al., 2018). The LPAA (Chapey et al., 2000; Holland & Elman, 2020) was discussed as currently influential in their work with individuals with aphasia.

This participant discussed previous collaborations of treating aphasia in group settings with music therapists, noting mixed outcomes. Some collaborations were described as having limited success while others as being highly successful. Factors that influenced the success of the collaborations included the structure and number of sessions offered and the skill of the MT. They suggested a series of 8 - 10 weekly group sessions as most effective in encouraging client participation. The predictable yet flexible structure of the sessions was also cited as having a positive impact on participation and client outcomes. P1 viewed the MT’s musicality and ability to inspire and “convey the value” of music therapy to the participants as influential to the success of the collaboration.

P1 also identified and described various music interventions - vocal warm-ups, lyric substitution and fill-in-the-blank songwriting methods, music and relaxation, and singing familiar songs - that they perceived to be particularly beneficial to participants. Additionally, intentional use of PowerPoint slides during online sessions had a positive impact on group outcomes. The importance of socialisation and conversation in increasing brain stimulation was discussed and P1 described group music therapy as a “novel and highly beneficial” opportunity for communication and brain stimulation. In P1’s words: “Music therapy ... where you just relax, and communication just happens embedded in something else is possibly the added magic of the offering of music to people with aphasia.”

P1 discussed psychosocial aspects of aphasia including comorbid mood disorders and identity changes in clients. P1 observed that psychotherapy and counselling skills were “not really embedded” in the SLP training they received. They shared knowledge of pediatric play-based interventions, which they identified as most similar to counselling skills in their education. Their reference to play-based interventions appeared to correspond well with their interest in LPAA and music therapy. P1 perceived that clients receiving care from professionals, such as SLPs, occupational therapists, and physiotherapists, often expect the practitioner to “fix” them. P1 commented that it is often not possible to “repair [a speech impairment] to the extent that the individual wants it repaired” which has required SLPs to “look at a positive way of going through rehab[ilitation].” Based on what P1 shared, they

appeared to imply that basic counselling skills for SLPs could be useful in facilitating clients' adjustments to the challenges of having aphasia, including tempering clients' expectations regarding realistic rehabilitation goals.

During the conversation, P1 discussed challenges in determining best practices for the treatment of aphasia. These challenges involved broad issues, such as the evolution of theoretical frameworks in research and practice, and difficulty in demonstrating to funders the positive impacts of social frameworks of treatment and rehabilitation.

Participant 2

Participant 2 (P2) indicated that they did not have formal musical training, but they had experience singing in a choir as a child and a general appreciation for a wide variety of music. They indicated that they generally had positive experiences of interdisciplinary collaboration with dietitians and occupational therapists but did not have the opportunity to collaborate with a music therapist. They also identified skills or traits that contributed to successful collaboration as "openness to other ways of thinking," curiosity and desire to learn, and mutual prioritisation of clinical goals. They shared that part of their motivation in volunteering for this research project was to learn practical ways of incorporating music into their clinical work and finding resources for connecting with MTs in their region.

In discussing their perceptions of music therapy, this participant noted that music therapy is an effective resource in treating speech disorders such as aphasia and that they would like to learn more about practical aspects of treatment. P2 described language impairment assessment as a "challenging experience" for patients and "not necessarily the best for building rapport." This reflection led P2 to "wonder if rapport building would be easier for [MTs]" due to the "motivating" and "immediately gratifying" nature of music.

P2 described their previous experience of treating aphasia in individual and group settings. An overview of the clinical process for individual and group treatment of aphasia highlighted various clinical priorities at different stages of treatment. In discussing how music could fit into aphasia treatment at various stages, they noted that they had previously tried MIT but found it not very effective. They shared that they were uncertain if they were facilitating it correctly. P2 did not indicate if they had received specialised training in MIT facilitation. Additionally, they shared that they had engaged clients in singing familiar songs, such as Happy Birthday, with the intent of using music to access automatic language.

Drawing while listening to music was discussed as another possible intervention for aphasia treatment. I shared my experience of facilitating this as a form of improvisation. I indicated that drawing to music can support clients in expressing and externalizing their thoughts and emotions, and that adopting an improvisatory approach could promote a sense of freedom for clients. P2 appreciated this idea and shared that they thought it could be a beneficial way for SLPs to approach the common rehabilitation goal of holding a writing implement. P2 elaborated, sharing that in their experience, clients are sometimes apprehensive about trying to write and can become discouraged by the results of their efforts. P2 indicated that they thought drawing while listening to music could release the pressure to achieve expected outcomes and therefore reduce apprehension and frustration

experienced by clients. Listening to preferred music and song-sharing were also discussed. I described these as simple but effective ways to promote agency and offer validation to clients through intentional choice-making. P2 thought that this was a music intervention they could support clients with and suggested that selecting preferred music could be included as a “goal” for some clients.

Psychosocial aspects of aphasia conditions were discussed, including change of identity and the development of mood disorders in clients with aphasia. P2 indicated that they had received additional training in motivational interviewing to expand their skill set when treating patients with aphasia. They also shared experiences in observing a correlation between the severity of language impairment and the likelihood of a patient developing a mood disorder.

Participant 3

Participant 3 (P3) described having a strong musical background, including formal instrumental training. They indicated that, before becoming an SLP, they had been interested in pursuing music therapy as a career. They also shared that “[music] never leaves you” and accordingly find that they are able to incorporate music into aphasia treatment, when working independently and in collaboration with the MT at their place of employment.

This participant described their experience collaborating with the onsite music therapist as primarily positive and shared that they “think there needs to be more collaboration.” This collaboration occurred primarily in the in-person treatment of individual patients. Collaborative treatment was described as being effective in targeting three domains: language, cognitive communication, and voice. Language domain interventions involved composing and singing songs to encourage specific language goals such as naming the days of the week. Cognitive communication interventions were targeted at improving attention and working memory through rhythmic or melodic pattern recognition and re-production using drums or other instruments. P3 noted that words were sometimes added to the patterns, where appropriate. Vocal domain interventions involved improving breath support, encouraging phonation, and singing.

P3 shared that they felt “very lucky” to be able to offer co-facilitated treatment to individual patients with aphasia. They noted that co-facilitated treatment of individual clients may be considered “expensive” but that they “didn’t see it that way” due to the numerous positive outcomes of this sort of treatment. In discussing the skills or traits that contributed to the successful nature of their collaborations, P3 cited their personal musicianship skills and “coming in with an open mind” as having positively impacted their ability to collaborate effectively with MTs. They noted similar attributes in their collaboration partner as having a positive impact on the collaboration. Additional factors that appeared to positively impact collaborative treatment were clarity of facilitator roles, clinical goals, and treatment plan.

P3 provided insights into the positive outcomes of collaboration with MTs, describing benefits related to professional growth, clinical scope, and client experiences. Mutual learning was the primary professional benefit of collaboration with music therapists. The process was described by P3 as “kind of magical” and akin to a “jam” session noting “that’s when my brain activates.” Collaboration with MTs was also noted to expand the scope of treatment by allowing for the possibility of addressing psychosocial and wellness goals, noting that “it [music] makes people happy.” Finally,

this participant noted they observed collaborative treatment of aphasia with music therapists often resulting in unexpected outcomes for clients describing this phenomenon as “the magic of music.”

Although they experienced many positive collaborative experiences, they also identified challenges in initiating collaboration, related to changes in workplace environments and a misunderstanding of the scope of MT.

THEMATIC ANALYSIS

The thematic analysis resulted in three themes – *Personal Aspects*, *Clinical Aspects*, and *Systemic Challenges* – for the collaborative treatment of aphasia (Figure 1). For the Personal Aspects theme, four sub-themes were identified - *openness*, *musicianship skills*, *confidence* and *professional learning*. Four sub-themes of the Clinical Aspects theme were identified - *establishing common goals*, *clarity of facilitator roles*, *diverse music interventions* and *expanded scope of practice*. Two sub-themes of the Systemic Challenges theme were identified: *determining best practice* and *workplace culture*. Two sub-sub-themes of the determining best practice sub-theme were identified: *demonstrating the benefits of collaborative treatments* and *securing funding*. Two sub-sub-themes of the workplace culture sub-theme were identified: *attitudes towards collaboration* and *attitudes towards music therapy*.

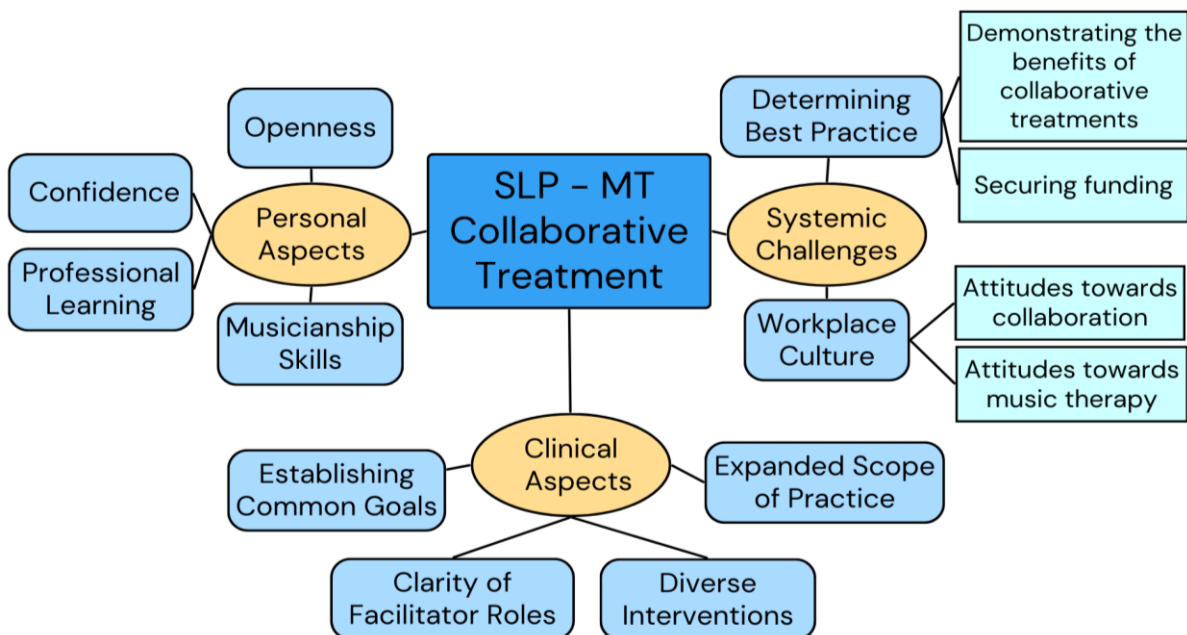


Figure 1: Thematic analysis of all participant interviews (alternative text description in the Appendix C)

Personal aspects of collaboration

Personal aspects of collaboration included personal traits which were perceived to support collaboration and ensure beneficial outcomes to clients and practitioners of interdisciplinary collaborations. These were Openness, Musicianship skills, Confidence, and Professional learning.

Openness and related personal traits were perceived by all participants as positively influencing collaborative treatments. Openness was described in a few ways such as a “willingness to collaborate” (P3), receptiveness towards “other ideas and other ways of thinking” (P2), curiosity, and enjoyment of learning (P2). Openness was identified as an important element of collaboration for both SLPs and MTs. Facilitator adaptability during sessions was also described by P1 as important in facilitating aphasia treatment.

Musicianship skills were cited by two participants as having an impact on the quality of collaborative treatment of aphasia. Discussion of musicianship skills related to both SLP and MT musical skill and experience. P3 described both the value of their own musical training and the expertise of the music therapist as being important to the success of previous collaborations. They described their musical training as helpful in understanding how the elements of collaborative treatment “tie in together.” P1 described the success of previous collaborations with MTs as related to the skill of the MT and the quality of musical experiences. In their experience, more successful collaborations involved musical experiences which were “inspiring” and in turn motivating to the participants.

Confidence in professional competencies was cited by two participants as being important to the success of interdisciplinary collaborations. Participants described confidence as the professional’s ability to not feel “intimidated” (P3) or “threatened” (P1) by the skill and expertise of their collaborator. This was described as an important quality for both MTs and SLPs.

Professional learning was perceived by two participants to be an important aspect of interdisciplinary collaborations. P2 perceived that their natural curiosity and enjoyment of learning contributed to making collaboration a “more positive experience” (P2). P3 noted that they learned a lot from their collaborations with MTs. It appears that the desire to learn can play a role in the success of interdisciplinary collaborations. Additionally, professional learning can be a positive outcome to practitioners of interdisciplinary collaborations.

Clinical aspects of collaboration: what, how, and why?

The clinical aspects of interdisciplinary collaboration explored the questions of what elements are important to the success of collaborative treatment, how we facilitate collaborative treatment, and why collaborative SLP-MT treatment of aphasia is important. Specific aspects related to each of these questions included Establishing common goals, Clarity of facilitator roles, Diverse interventions, and Expanded scope of practice.

Establishing common goals was perceived as important to the success of interdisciplinary collaborations by all participants. P2 attributed their positive experiences with collaboration to having a shared goal for treatment which becomes “top priority.” P1 and P3 also described the collaborative nature of determining “shared goals” (P1) and “making a [treatment] plan together” (P3). Establishing

common goals within a treatment plan appears to be foundational to the success of collaborative treatment because it provides a framework for treatment and guides decision-making related to how we facilitate collaborative treatment.

Clarity of facilitator roles was identified by two participants as important for successful interdisciplinary collaborations. This theme was discussed in relation to the following aspects of the clinical process: assessment, treatment planning, and treatment facilitation. Facilitator roles were revealed to vary depending on the client and nature of the clinical process. P3 described the importance of knowing and staying within their scope of practice as an SLP. Additionally, P3 indicated that in previous collaborations with MTs, they had been responsible for assessing the client and determining treatment goals. P1 described the role of facilitators in a broader sense as co-creating an “inspiring” and therapeutic environment for clients. Clarity of roles regarding treatment facilitation is included in the discussion of musical interventions below.

Diverse music interventions were identified as supportive to aphasia treatment. Table 1 provides a summary of music interventions discussed by the participants.

Intervention name and description	Treatment domains and goals	How is it facilitated? (roles)	Additional considerations
Songwriting through Lyric Substitution	Psychosocial <ul style="list-style-type: none"> • Creative expression • Self-expression Language <ul style="list-style-type: none"> • Word cueing 	Co-facilitated	Choose songs strategically to balance predictability and creativity. Group or individual sessions
MT composed songs	Language <ul style="list-style-type: none"> • Specific goals such as saying the days of the week. 	Co-facilitated is best. Could be facilitated individually once the song is created depending on musical skill and comfort of the facilitator.	Group or individual sessions
Song-sharing (Choosing, listening and discussing preferred music)	Psychosocial <ul style="list-style-type: none"> • Promoting agency through choosing songs. 	Co-facilitated or individually facilitated by MT or SLP	Group or individual sessions
Melodic or Rhythmic Pattern Copying	Cognitive <ul style="list-style-type: none"> • Memory • Attention Psychosocial <ul style="list-style-type: none"> • Turn taking 	Co-facilitated or individually facilitated by MT or SLP	Group or individual sessions
Melodic Intonation Therapy (MIT)	Language <ul style="list-style-type: none"> • improving expressive language 	Individually facilitated by MT or SLP	Individual sessions

Singing Familiar Songs	Language <ul style="list-style-type: none"> • Accessing automatic language Psychosocial <ul style="list-style-type: none"> • Relaxation 	Co-facilitated or individually facilitated by MT or SLP	Group or individual sessions
Vocal and Movement-Based Warm-ups	Vocal <ul style="list-style-type: none"> • Phonation • Breath support Psychosocial <ul style="list-style-type: none"> • Relaxation • Somatic awareness 	Co-facilitated or individually facilitated by MT or SLP, depending on comfort of facilitator.	Group or individual sessions
Music and Guided Relaxation	Vocal <ul style="list-style-type: none"> • Breath support Psychosocial <ul style="list-style-type: none"> • Relaxation • Somatic awareness 	Co-facilitated or individually facilitated by MT or SLP	SLP may wish to choose pre-recorded music if facilitating individually. Group or individual sessions
Drawing to Music	Movement/motor <ul style="list-style-type: none"> • Holding a writing implement Psychosocial <ul style="list-style-type: none"> • Self-expression • Creative expression 	Co-facilitated or individually facilitated by MT or SLP	Group or individual sessions

Table 1: Music Therapy (MT) and Speech-Language Pathology (SLP) Interventions for Aphasia

Expanded scope of practice was perceived as a result of collaborative treatment and to provide benefit to clients by allowing co-facilitators to address a wider range of treatment domains. Psychosocial aspects of wellness and treatment emerged as a primary benefit of SLP-MT treatment of aphasia. P2 noted that language assessment can be a challenging experience for clients with language impairments and perceived this to be a challenge in developing rapport with clients. They perceived music therapy as a profession well suited to developing rapport with clients due to music being “more immediately gratifying” and “motivat[ing]” (P2). Additionally, two participants discussed the possibility for unexpected positive treatment outcomes in collaborative treatment of aphasia between SLPs and MTs. P3 noted that in their experience, additional benefits to the client “seep through once you start music therapy.” P1 shared that “any form of stimulation is beneficial” to clients even when the outcomes are “not necessarily what you were intending.”

Systemic challenges to collaboration

All participants identified various systemic challenges to initiating collaborative SLP-MT aphasia treatments. Systemic challenges related to broad professional issues, such as determining best practices for treatment, and attitudes towards music therapy and interdisciplinary collaboration within institutions which typically employ SLPs and MTs.

Determining best practice includes demonstrating the benefits of and securing funding for music therapy and collaborative treatment of aphasia. This was perceived as a challenge to initiating collaborative treatment, attributed to shifting values underpinning theoretical frameworks and approaches to research and aphasia treatment. P1 noted that funders typically want to see how treatment “fix[es]” language impairment and that SLPs are “constantly trying to demonstrate” the value of improving quality of life for individuals with aphasia. P3 also perceived that collaborative SLP-MT treatment is considered an “expensive” treatment option by funders. P3 also shared that they and their previous collaborating partner (MT) “don’t see it that way,” and perceived the increased benefits of collaborative treatments to outweigh the increases in cost.

Workplace culture and attitudes surrounding collaboration and music therapy were identified as having a negative impact on participants’ attempts to find collaboration partners and to initiate opportunities for interdisciplinary collaboration. P3 described an inconsistent valuing of interdisciplinary collaboration in their place of employment. This was attributed to a lack of understanding of the “significance” and benefits of joint SLP-MT sessions. P3 also suggested that practitioners may be hesitant to participate in collaborative care if they hadn’t had previous exposure to interdisciplinary collaboration.

P2 also experienced uncertainty in knowing where to connect with MTs and expressed a desire for resources to help find collaboration partners. P1 noted that, although they were open to collaborating with music therapists, opportunities for collaboration had been few, and many collaborations had been brief with mixed outcomes.

DISCUSSION

The interview findings described three SLPs’ experiences of collaborating with MTs and incorporating music into aphasia treatment. Thematic analysis provided further description and delineation of specific aspects of collaborative SLP-MT treatment of aphasia. This section presents an interpretation of the findings, conveyed in three main sections: Qualities of positive collaborative experiences, the Role of music in SLP-MT collaborative treatment of aphasia, and Reasons for not choosing music in aphasia treatment.

Qualities of positive collaborative experiences: Balance between structure and freedom

The thematic analysis identified three themes of SLP-MT collaboration, discussed in the previous section. Reflections on the data revealed an overarching thematic principle of balance between structured and mutable elements of collaborative aphasia treatment. For the purposes of this discussion, mutable, adaptable, or flexible aspects of treatment will be referred to as elements of freedom. The balance between structure and freedom is noted and described across all three themes.

Sub-themes within the personal aspects of collaboration theme which embody the balance between freedom and structure include Openness and Confidence. Openness is marked by curiosity, receptiveness towards diverse ideas and adaptability. Within the collaborative clinical context,

openness allows clinicians the freedom to approach clinical work in a co-creative way. Confidence in professional competencies is distinguished primarily by a clinician's assurance in their expertise and skill. This is important because it provides clinicians with a foundational structure for understanding their contributions and role within interdisciplinary collaborations. Bar et al. (2018) recognise that health-care professionals' attitudes towards interdisciplinary collaboration contribute to effective teamwork. They identify personality traits such as "openness to experience" (p. 41) and professional attributes such as "competency and autonomy" (p. 41) as crucial components of positive attitudes towards interdisciplinary collaborations and "collaborative working environments" (p. 41).

Within the clinical domain of collaboration, the qualities of freedom and structure were represented across all themes: goals, roles, interventions, and unexpected outcomes. Establishing common goals and clarifying facilitator roles were described as crucial for providing structural guidance during interdisciplinary collaborations. The musical interventions experienced and described by participants are particularly significant because they contain the capacity for offering both structure and freedom in clinical collaborations. The nature of the interventions used provided structure to the clinical process. Client-centred facilitation of the interventions allows for adaptability and freedom within the clinical process. All participants described the importance of a balance between structure and freedom within their experiences noting that these elements had the capacity to reduce the pressure experienced by clients and often resulted in positive "unexpected outcomes" (P1 and P3). P1 described the value of flexible vocal warm-ups, which allowed participants the opportunity to discover their voices in a creative way with no demands and expectations. P1 also describes the value of both structure and freedom embedded in fill-in-the-blanks song modification interventions. They note that the familiarity and structure of the song provided predictability and the opportunity to change the lyrics offered freedom through creative selection of personalised lyrics. Hurkmans et al. (2020) also note the importance of balance between structure and freedom. They describe SMTA as a "dynamic process" in which "musical elements are interwoven" to provide standardised and personalised care to clients (p. 948).

Systemic aspects of collaboration - such as determining best practice and securing funding, and workplace culture and attitudes - were primarily described by participants as contributing to challenges faced in initiating interdisciplinary collaborations. Determining best practice in clinical care and securing funding for collaborative treatment of aphasia are reliant on research which demonstrates the effectiveness of various types of interventions and treatment protocols. Challenges demonstrating the value of collaborative treatments were described by participants as related to a need for more research regarding the benefits of collaborative treatment and a need to conceptualise "impairment within a more encompassing value system" (P1). Merrett et al. (2019) also explore challenges in determining best practice by discussing the often incongruent nature of efficacy research and clinical work. They note that "research is generally focused on standardization, generalizability, and the provision of adequately powered and statistically sound evidence. In contrast, clinical work is usually client-centric, requiring flexibility to address the needs of the individual patient" (p. 429). These examples are interesting because they allude to an imbalance between structure and freedom within the systemic aspects of collaboration.

I found the personal and clinical aspects of SLP-MT collaboration unsurprising as I had experienced the usefulness of those qualities during collaborative experiences in my internship. In discussing the systemic challenges of SLP-MT collaborations, I learned a great deal from the participants. At times, there appeared to be an undercurrent of frustration towards the systemic challenges they had experienced. I found this to be revealing of their passion towards their work and commitment to the clients they serve.

The magic of music: Describing the role of music in SLP and MT aphasia treatment

During initial interviews with participants, collaborative experiences involving music were described as “magic” by both P1 and P3. What is the role of music and music therapy in interdisciplinary collaborations? This section explores the role of music in interdisciplinary collaborative treatment of aphasia through a music psychotherapy student’s perspective. Through this, I begin to demystify music therapy and the impact of music in aphasia.

The overall qualities of positive collaborations were described in terms of a balance between structural elements of clinical work and freedom, or as flexible elements of clinical process. This balance is intrinsic to music therapy practice, using music’s inherent structural elements and the freedom to modify these elements. Bruscia’s (1987) landmark text describes numerous models of improvisational music therapy. A common feature among the models is the discussion of musical form and ways to incorporate structure and freedom within therapy sessions to best serve the clients’ needs. Collective music-making is an inherently collaborative process in which various structural elements of music are combined and experienced in novel ways (Wigram, 2004). Each music-maker is a participant in this process, making it well suited to a client-centred approach.

In addition to a client-centred focus, it is common for music therapists to approach clinical work with a resource-oriented framework (Rolvsjord, 2010). This involves “nurturing [the] strengths, resources, and potentials” (p. 74) of the client, rather than the limitations of their diagnosis or disability. Within this framework, a client’s innate musicality is considered to be a resource, so a resource-oriented focus offers agency and choice to clients by fostering an environment which allows for musical co-creativity and collaboration between clients and clinicians. A resource-oriented approach to music therapy aligns well with sociological frameworks of communication and aphasia care, such as the LPAA.

The idea of equating music with magic is interesting and familiar to me. In reflecting on this idea, I experienced conflicting responses. I first noticed that my thoughts moved towards early formative musical experiences, such as the first time I heard a favourite song on the radio or played in an ensemble. These are moments where I remember feeling the magic of music which was often composed of sensory and/or emotional experiences such as tingling, a headrush, butterflies in the stomach, and/or a sudden and brief wave of emotions. In contrast, I felt that likening music to magic could be perceived as overlooking the many years of musical practice and clinical training that music therapists undertake to develop and hone their skills.

Another interesting topic that arose in conversation with P2 was the role of music in developing rapport with clients. P2 wondered if music might assist in building rapport. My first response was to agree. However, I recognised that caution was required with this assumption. Music therapy can be an enjoyable and empowering way to encourage self-reflection and connection with others. However, music therapy can also elicit unexpected responses which may not be beneficial or pleasant to the client, so music can be contraindicated in some cases. Therefore, it is important to recognise that if music is used inappropriately, it may not be helpful in building rapport. More research and advocacy work are needed to unravel the “magic” of music, understand the multi-faceted impact of music, and clearly define the role of music within aphasia care and SLP-MT collaborations.

Reasons for not using music

Participants noted that, in their experience, MTs’ scope of practice appears to be less understood than that of other allied health professions. This suggested a lack of understanding regarding the role of music therapists, the clinical processes used in music therapy, and the mechanisms which make music therapy an effective treatment for aphasia. Participants also indicated a lack of access to music therapy as a resource for interdisciplinary collaboration, due to very few music therapists being employed at their workplaces. Additionally, P3 observed that, in their workplace, the MT appeared to experience limited access to resources. Although they didn’t elaborate on the nature of the resources, they did note that the MT was employed at their workplace on a part-time basis. I related to P3’s comment about limited resources because of experiences during my multisite internship. Access to office and clinical spaces, music instruments, and technology varied from site to site and was limited at times.

Among MTs it is known that advocating for your profession is often necessary for employment (Kern & Tague, 2017). This “burden of advocacy” is a common reason for music therapists to seek employment in other professions which are more well-established (Branson, 2023, p. 15). Interdisciplinary advocacy has the potential to relieve some of the burden faced by music therapists. Additionally, continued research exploring explanatory neurological theories for incorporating music into aphasia care, research exploring clients’ experiences in receiving collaborative MT-SLP aphasia care, and investment in clinical and professional resources could support advocacy efforts and improve clinical care.

The participants’ observations regarding barriers to using music in aphasia treatment were unsurprising to me due to my internship experiences. During my multisite internship, I noticed contextual variation in how music therapy and interdisciplinary collaboration were understood and valued. At internship sites where interdisciplinary collaboration was actively encouraged through site-specific educational programming, the understanding of music therapy was greater and music therapists and interns were more integrated into the facility and treatment teams. At internship sites without embedded interdisciplinary training, opportunities for collaboration tended to rely on individual practitioner’s openness and willingness to collaborate and work with students.

CONCLUSIONS

Conducting this research has increased my understanding of speech-language pathology practice and theories as they relate to aphasia. This project has enabled me to reflect on how I conceptualise the role of the music, apply it in clinical work, and communicate this with clients and colleagues. I intend to continue seeking out opportunities for collaboration and consider how I can contribute to creating tools for developing collaborative practices. The small sample size of this study allowed for flexibility in the interview process, which resulted in the collection of rich and interesting data.

Insights gained from this data revealed systemic challenges in initiating and maintaining collaborative environments and offered ideas for supporting clinical work and advocacy. Systemic challenges identified included a lack of resources for connecting with music therapists, workplace culture and attitudes towards collaboration, and the ongoing process of determining best practices in aphasia treatment. Potential solutions include process-driven systems and resources within organisations for encouraging interdisciplinary collaboration, more aphasia research including the impact of music and benefits of collaborative treatment, and opportunities to observe interdisciplinary collaboration.

In sum, increased awareness of MTs' scope of practice and music-based interventions that require no prior musical training might encourage hesitant SLPs to use music and to collaborate with an MT.

Limitations

This study is limited primarily by the small sample size which may reduce generalisability of the results. The time constraints of completing a research project in a Master's level program prohibited collecting data from a larger sample size. Further research with a larger sample is suggested. It was encouraging that each participant indicated an interest in music therapy and interdisciplinary collaboration. However, future research could involve participants who hold less welcoming views towards interdisciplinary collaboration.

Suggestions for future research and practice

Based on this small-scale study, it is recommended that future research includes investigation of the efficacy and benefits of collaborative MT-SLP treatment of aphasia, barriers to collaboration, and resources for fostering collaborative environments. Additional recommendations for research include investigation of the challenges in determining best practice and applying research to clinical practice, and exploration of both client and clinician perspectives. This research has motivated the first author to explore options for pursuing a collaborative practice.

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APPENDIX A

Interview Guide

Describe your path to becoming a speech language pathologist.

Describe your experience in treating people with aphasia.

How do you incorporate music into your treatment protocols for people with aphasia?

Describe your experiences of collaborating with music therapists to treat aphasia.

- What factors do you think contributed to the success or failure of this collaboration?

What benefits do you perceive in using music therapy to address aphasia?

What limitations do you perceive in music therapy scope of practice in treating aphasia?

Do you think that there are limitations in your own scope of practice as a speech language pathologist?

- What are those perceived limitations?

What sorts of responses do you notice in clients with aphasia when using music and/or participating in music therapy?

- How do these responses differ from sessions with no music?
- How does it feel to observe these responses in participants/clients?

What sort of practical advice would you like to share with other speech language pathologists who want to incorporate music into their treatment protocols for people with aphasia?

What sort of practical advice would you like to share with music therapists treating aphasia?

APPENDIX B

Results Interview / Questionnaire

Please describe aspects of the results that you agree with, if any.

Are there aspects of the results that you find surprising?

- If yes, please describe those aspects.

Please provide any further comments regarding the results of this study.

Please describe the impact that this research will have on your work with individuals with aphasia.

Please describe the impact this research will have on your interdisciplinary collaborations in the future.

Please provide any other comments you have regarding the results of this study.

Please provide any other comments you have regarding your experience of participating in this study.

APPENDIX C

Alternative Text Description of Figure 1

Thematic Analysis of All Participant Interviews

Figure 1 contains a flowchart which provides an overview of the 3 themes, 10 sub-themes and 4 sub-sub-themes of SLP-MT Collaborative Treatment. Themes, sub-themes and sub-sub-themes are listed here:

SLP-MT Collaborative Treatment

Personal Aspects

- Openness
- Musicianship skills
- Confidence
- Professional learning

Clinical Aspects

- Establishing Common Goals
- Clarity of facilitator roles
- Diverse interventions
- Expanded Scope of Practice

Systemic Challenges

- Determining Best Practice
 - Demonstrating the benefits of collaborative treatments
 - Securing funding
- Workplace Culture and Attitudes
 - Attitudes towards collaboration
 - Attitudes towards music therapy

Εύρεση κοινού πεδίου: Διερευνώντας τις εμπειρίες των λογοθεραπευτών από τη συνεργασία τους με μουσικοθεραπευτές στη θεραπεία ατόμων που ζουν με αφασία

Christine Hudson | Heidi Ahonen

ΠΕΡΙΛΗΨΗ

Σκοπός αυτής της φαινομενολογικής μελέτης ήταν να διερευνήσει τις εμπειρίες των λογοθεραπευτών (ΛΘ) από τη συνεργασία με τους μουσικοθεραπευτές (ΜΘ) στη θεραπεία ατόμων με αφασία. Η ανάλυση των δεδομένων έδωσε μικτά αποτελέσματα, αναδεικνύοντας/εντοπίζοντας πτυχές που υποστηρίζουν και δυσκολεύουν τη συνεργασία. Τα δεδομένα συλλέχθηκαν από ημιδομημένες συνεντεύξεις με τρεις συμμετέχοντες. Οι συμμετέχοντες ήταν λογοθεραπευτές που είχαν εμπειρία στη θεραπεία ατόμων με αφασία σε νοσοκομειακά και κοινοτικά περιβάλλοντα. Η θεματική ανάλυση χρησιμοποιήθηκε για τον εντοπισμό των παραμέτρων που προέκυψαν από τη συνεργασία ΜΘ-ΛΘ στη θεραπεία της αφασίας. Τα αποτελέσματα ανέδειξαν τα παρακάτω θέματα: προσωπικές και κλινικές πτυχές, καθώς και συστημικές προκλήσεις των συνεργασιών ΜΘ-ΛΘ. Η ανατροφοδότηση των συμμετεχόντων σχετικά με τη θεματική ανάλυση ενσωματώθηκε στη συζήτηση, η οποία παρουσιάζει πληροφορίες σχετικά με τις γενικότερες ιδιότητες της επιτυχημένης συνεργασίας ΜΘ-ΛΘ και τη συμβολή της μουσικής στη θεραπεία της αφασίας. Η έρευνα παρέχει έναν κατάλογο μουσικών παρεμβάσεων που μπορεί να αποτελέσει πηγή για τους ΛΘ και τους ΜΘ στη θεραπεία της αφασίας. Επιπλέον, τα θέματα που συζητούνται στην παρούσα μελέτη μπορούν να βοηθήσουν τους ΛΘ και τους ΜΘ να προωθήσουν τη συνεργατική φροντίδα των ατόμων που ζουν με αφασία.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

φαινομενολογία, μουσικοθεραπεία, παθολογία ομιλίας και γλώσσας, αφασία, διεπιστημονική συνεργασία

ARTICLE

A first-person phenomenological pilot case study exploring the efficacy of using whole-body low frequency sound vibration to treat stress and anxiety

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ABSTRACT

The purpose of this pilot first-person case study was to test if whole-body low frequency sound vibration decreases stress and anxiety and to evaluate the equipment used to measure the effects of vibration to inform a more extensive, long-term clinical study in the future. The Next Wave Physioacoustic Chair was used to apply the treatments, which consisted of six 20-minute sessions spread out over 15 days. Qualitative data consisted of daily journal entries and pre- and post-treatment observations. A phenomenological analysis involved the identification of emerging themes. Quantitative data was collected using a Garmen Vivosmart 4 device worn on the wrist twenty-four hours daily (except when charging). The device measured pre- and post-treatment heart rate, heart rate variability (HRV), and sleep quality. An overall stress score was computed using HRV measurements and sleep. The results showed that Physioacoustic treatment can have a positive effect on stress and anxiety levels. This was shown by a consistently lowered heart rate following each treatment, increased body awareness and connection, decreased pain and tension, and a sense of relaxation, calm, mental clarity, and focus. The recommendation is for further long-term studies using a more significant number of participants reporting high levels of stress and anxiety along with control groups. Further studies may also benefit from incorporating electroencephalogram (EEG) measurements to examine brainwave activity to further understand stress-related outcomes.

KEYWORDS

low frequency sound,
vibration,
anxiety,
stress

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INTRODUCTION

Stress and anxiety are natural defence responses to the world around us. However, they can become pathological and interfere with daily life. In recent years, a focus on mental health has emerged with staggering statistics. By the time Canadians reach 40 years of age, half of them have experienced some level of mental illness (Centre for Addiction and Mental Health, 2021). Anxiety can affect people of all ages, genders, and backgrounds. It can lead to other serious illnesses, shorten life expectancy reduce quality of life and negatively affect the economy (Meier et al., 2016; Wilmer et al., 2021). A report conducted in 2016 by the Conference Board of Canada found that lost productivity due to workers' anxiety costs over \$17 billion a year (Anxiety Canada, 2016). An Ipsos Reid poll conducted in Canada in 2021 found that 56% of Canadians experience increased stress or anxiety as a result of COVID-19. With a rise in significant stressors such as the COVID-19 pandemic, the global climate crisis, and political unrest in many parts of the world, anxiety levels seem to be on the rise. There are many methods used to manage anxiety, such as medication, mindfulness practices, physical activity, and massage therapy. Every person experiences anxiety in unique ways and responds differently to various treatment methods. Affordability, availability, and accessibility of treatment can also be factors in which methods are available in each case.

The purpose of this study was to explore the efficacy of low-frequency sound vibration of the Next Wave Chair to treat and manage stress and anxiety. This study also explored the equipment used to measure the effects of low-frequency sound vibration to inform a more extensive, long-term clinical study in the future. This study tracked heart rate activity and daily stress as indicated by the Heart Rate Variable (HRV) measurements, sleep cycles, and oximeter readings in real-time. This treatment is currently only available in a couple of clinics in Canada. However, other low-frequency devices are more accessible, available, affordable, and portable, e.g., in-home consumer devices like Sound Oasis VTS1000 (Sound Oasis, 2016).

This was a first-person case study. The first author was the research participant and the researcher. She first heard about the use of low-frequency sound vibration a few years ago after her mother was diagnosed with dementia and she became interested and involved in an Alzheimer's study. This led to her curiosity about the potential effects of this type of therapy for anxiety. As a woman who has experienced issues with anxiety for several years, she was interested in exploring the possibility that this treatment could also be used to help alleviate the symptoms of anxiety. As a music therapist, she felt that her experiences with this treatment might integrate well into her music therapy practice when working with clients suffering from stress and anxiety.

LITERATURE REVIEW: LOW FREQUENCY SOUND VIBRATION, STRESS, AND ANXIETY

Low-frequency sound vibration utilising various devices (e.g., Physioacoustic Next Wave chairs, Vibroacoustic beds, and Somatron, Sound Oasis) have been studied to treat a wide range of health issues (Ala-Ruona & Punkanen, 2017). Among many of these studies, a common finding is a reduction in stress and anxiety. One study on a vibrobed device found some effect on heart rate variability, stress perception, and mood following the treatment. However, the researchers proposed that the impact of

the low-frequency vibration may be different when combined with listening to music. They recommended this hypothesis be investigated in future studies (Vilímek et al., 2022). A similar statement was found in Kantor et al.'s (2022) study that investigated the benefits of the Vibrobed in managing stress among university students. Ahonen et al. (2012) used Physioacoustic Next Wave treatment with university students, faculty, and staff to study its potential benefits for overall well-being. The results of this pilot study showed that the treatment improved participants' subjective well-being, decreasing stress and pain, increasing emotional enrichment and concentration, and increasing emotional and physical relaxation levels.

There is also a known relationship between anxiety and pain perception, whether acute or chronic. Several studies have found that pain and tension decreased with the use of physioacoustic and vibroacoustic treatments (Ahonen et al., 2012; Boyd-Brewer & McCaffrey, 2004; Campbell et al., 2019; Naghhi et al., 2015).

According to Folk (2021), brain fog is often one of the symptoms of anxiety disorders. Interestingly, studies on the effects of Somatron (Brodsky, 2000) and Physioacoustic Next Wave chairs (Ahonen et al., 2012) have found that mental clarity, alertness, and focus can increase after use (Ahonen et al., 2012). Increased alertness and clarity were also noted in the Physioacoustic Next Wave treatment studies of Clements-Cortes et al. (2016a, 2016b, 2017).

Rüütel et al.'s (2004) study used vibroacoustic therapy along with music, verbal therapy, and drawing with a group of adolescent girls with eating disorders who reported symptoms of stress. This study found that participants benefited from vibroacoustic therapy by decreasing tension, increasing feelings of calm, and improving self and body awareness. Similarly, a study on individuals with drug addictions and trauma found that Physioacoustic Next Wave treatment helped clients become more in tune with and aware of their physical bodies (Punkanen, 2004). Somatron treatments were also reported to increase body awareness with a group of orchestra musicians (Brodsky, 2000).

There is also a connection between anxiety and sleep issues. In a study on patients with fibromyalgia, participants reported that regular sleep disturbances were decreased by 90 percent following an individualised course of 40 Hz low-frequency sound stimulation during vibroacoustic treatment (Naghdi et al., 2015).

METHOD

The research questions of this first-person phenomenological case study included the following:

- (1) How does whole-body low frequency sound vibration affect anxiety levels in an adult with a history of anxiety?
- (2) Can whole-body low frequency sound vibration be utilised as a tool to improve and maintain lower levels of anxiety?
- (3) What type of data and data collection tools provide the most complete measure of the effects of whole-body low frequency sound vibration on stress and anxiety levels?

DATA COLLECTION

The Next Wave Physioacoustic chair (see Image 1) was used for the application of the treatments consisting of six 20-minute-long sessions spread out over 15 days (Lehikoinen, 1990, 1997; Next Wave, 2015).

As this was a first-person case study, the first author was the research participant and researcher – she is a 41-year-old Caucasian woman. Stress and anxiety symptoms included headaches, sleep disturbance, occasional anxiety attacks, and neck and shoulder tightness. Qualitative data consisted of daily journal entries and pre and post low-frequency sound vibration treatment observations, and it was gathered using the research participant's self-observation, self-reflection, and retrospection (Bruscia, 2016).



Image 1: Physioacoustic next wave chair

Quantitative data was collected using a Garmin Vivosmart 4 device worn on the wrist 24 hours daily for 15 days (except when charging). The device was linked to the Connect application by Garmin on the iPhone to track real-time (pre- and post-treatment) daily heart rate activity, the overall daily stress score as indicated by the Heart Rate Variable (HRV) measurements, sleep cycles, and pulse oximeter readings. Stress levels (ranging from 0 to 100) on the Garmin device are estimated by the Firstbeat Analytics engine, which primarily utilises a combination of heart rate (HR) and heart rate variability (HRV) data. This information is collected by the optical heart rate sensor located on the back of the device (Garmin, 2024). The pulse oximeter on the Garmin device uses a combination of red and infrared lights, along with sensors located on the back of the device. This setup estimates the percentage of oxygenated blood in the bloodstream, known as peripheral oxygen saturation (Garmin 2024). Quantitative baseline data was collected one week before the low-frequency sound vibration period as a comparison.

INTERVENTION

The Next Wave Physioacoustic chair utilised in this study consisted of an armchair run by software that produced sound vibrations and afforded a whole-body somatosensory experience from its six speakers (see Fig. 1). The stimulation software was PhysAc.Net (2005). The device is approved by the Canadian Standards Association (CSA), the Food and Drug Administration (FDA; USA), and the British Standards Institution (BSI). It is classified as II: low-risk, non-invasive. The participant closed her eyes and kept her legs reclined and uncrossed when sitting in the chair. Lower legs, thighs, buttocks, lower back, and upper back were kept in contact with the surface of the chair at all times. Similar instructions were given in the previous studies of Mosabbir et al. (2022) and King et al. (2007). The sessions took

place at the Manfred and Penny Conrad Institute of Music therapy Research lab, and the research participant (first author) was alone in the room during the treatment. There were no music-listening interventions during the treatment. The treatment started with a relaxing programme customised and developed for the research participant by the second author. However, due to the computer software (Nextwave) suddenly crashing during data collection, this programme was utilised only during the first three sessions. As it was impossible to fix the computer/software issue immediately, the participant administered the last three sessions using the device's hand-programming unit and chose the 'relaxation programme' and volumes she felt comfortable with at the beginning of each session. The baseline measurements were taken one week prior to the start of the intervention.

Sessions 1–3

Thirty- and 40-Hz low-frequency sounds were applied for 20 minutes through whole-body vibrotactile somatosensory stimulation. The programme parameters unique to the Next Wave Physioacoustic treatment included time, frequency, scanning, speed, cycle of amplitude, direction of sound movement, and strength of sound pressure. The cycle of amplitude modulation systematically varied the amplitude of the low-frequency sound impulse from silence (amplitude = 0 dB) to the set maximum ($n > 0$ dB) and back to silence. The length was set at 2.6 seconds as per the participant's preference. The direction of the sound changed every 2 minutes. During the first 2 minutes, constant sound came from all speakers. During the next 2 minutes, the sound progressively moved from head to legs, and during the last 2 minutes, the sound moved from legs to head. This cycle was repeated over and over during the 20-minute program. The sound pressure was set for each speaker location – legs, thighs, back, and shoulder/neck – according to the participant's preference. The maximum volume was on the back area and feet. The lowest volume was on the neck area. The amplitude peaks and vibration metrics of displacement, velocity, and acceleration were not measured for this study. Similar to Mosabbir et al.'s (2022) study, the operational treatment frequency in this study was 30 and 40 Hz, which were alternated between these frequencies every 2 minutes. Similar to the studies by Clements-Cortes et al. (2016a, 2016b, 2017), these frequencies were set to scan between 29.93 Hz, 30.05 Hz, 39.86 Hz, and 40.06 Hz to avoid any mechano-receptor numbing effect. This resulted in a pulse-like sensation that causes a travelling sound pressure in the body, facilitating circulation (Lehikoinen, 1990, 1997).

Sessions 4–6

The Next Wave chair consists of several pre-set programmes: intensive programmes for a stimulating treatment and soft programmes for a relaxing treatment. The person sitting on the chair can administer these via a handheld controller unit. The person sitting on the chair can try different programmes and choose something they feel comfortable with at that moment. The different programmes focus on different body parts and the intensity of the vibration volume of each speaker can be adjusted according to the participant's preference. In this study, the research participant used different soft (relaxing) programmes during her last three sessions and adjusted the volume according to her needs and preferences. The frequencies ranged approximately between 27–60 Hz and the cycle duration was longer than 2.6 seconds during the last three sessions. Measuring the exact frequencies

or cycle durations was impossible. The participant simply chose something that 'felt good' in the moment.

DATA ANALYSIS

Qualitative data consisted of the research participant/researcher incorporating Van Manen's (1990) phenomenological perspectives by analysing her subjective lived experiences, her free-associated reactions to stress and anxiety, her breathing patterns, headaches, bodily sensations, energy levels, and emotional state during and after the low-frequency sound vibration.

Thematic, phenomenological analysis was performed manually on the free-associated journal entries and pre- and post-treatment observation reports. According to the principles of Van Manen (1990), the researcher participant/researcher reflected on the essential themes which characterised her low frequency sound vibration experience. This involved coding the data and identifying three main themes that had emerged throughout the data analysis.

During the first phase, the researcher read the journal entries and observation reports several times. After that she 'asked' herself, "What kind of experience is this?" Then she created particular meaning units, reflecting on the content of the experience and essential themes which characterised the phenomenon. Later on, these statements/phrases formed the beginnings of sub-themes and themes that gave meaning to the phenomena.

After the initial meaning units were set, they were re-read to search for meaning. The researcher asked: "What did this mean for me during the treatment process? During this phase, she was trying to apply thoughtfulness to an aspect of her lived experience and intending to make visible her feelings, thoughts, and body sensations. The emerging themes were then created to describe the low frequency sound experience. The researcher titled them so that they best described her experience and its meaning. The continual dialogue between seemingly meaningful words, phrases, and concepts, and questioning these sections of the text to ask "What is really being said here?" was an important part of the analysis process. After that, the themes were reviewed and questioned in light of all perspectives and questions. This process was a constant flow during the data analysis.

Finally, the descriptive categories and themes were created and named. According to abductive reasoning, each emerging theme was examined within the context of other literature and compared to the quantitative data to understand the phenomenon further. Three main themes are presented as the qualitative results of this study.

Quantitative data (HRV measurements, sleep cycles, and pulse oximeter readings) were first organised into an Excel chart developed by the researcher and then translated into bar graphs. The visual depiction of pre- and post-treatment results allowed the researcher to view emerging patterns.

RESULTS

The results of this pilot case study indicated that whole-body low frequency sound vibration can positively affect physical, mental, and emotional relaxation. The quantitative data collected focused on pre- and post-pulse rates, length and quality of sleep, and overall stress scores. Qualitative data findings include pain relief, body awareness, relaxation, mental clarity, and focus. The quantitative

data analysis findings will be introduced first, followed by a description of the three qualitative themes and quotes from the data.

Quantitative results

Heart rate

The comparison of heart rates before and after the session, along with the daily averages for resting and high heart rates, indicates that whole-body low-frequency sound vibrations may reduce heart rate, suggesting a decrease in stress levels.

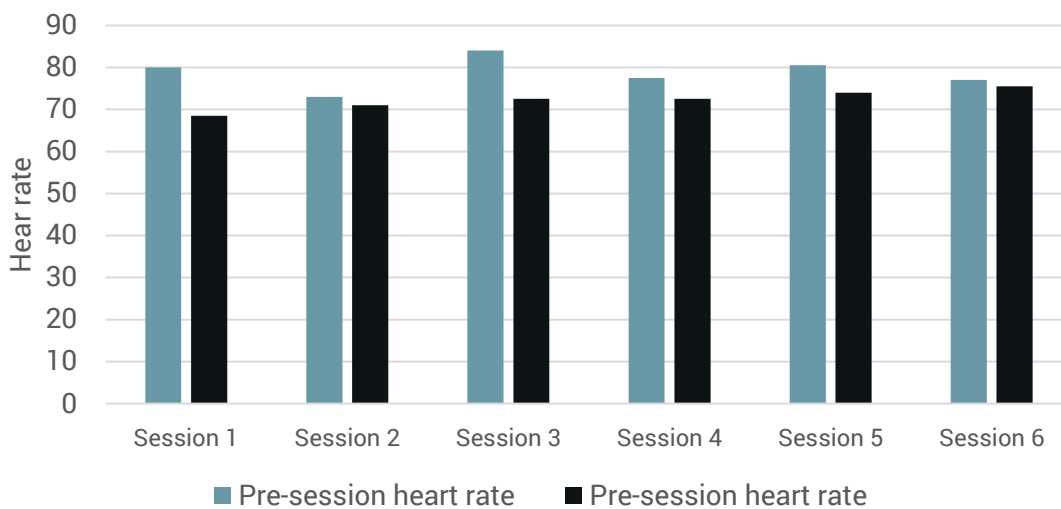


Figure 1: Pre-post session heart rate comparison

The results showed a consistent decrease in heart rate from pre-session to post-session, averaging 6.33 beats per minute in post-treatment heart rates. Figure 2 shows the overall daily resting and high heart rate averages throughout the baseline week and testing period.

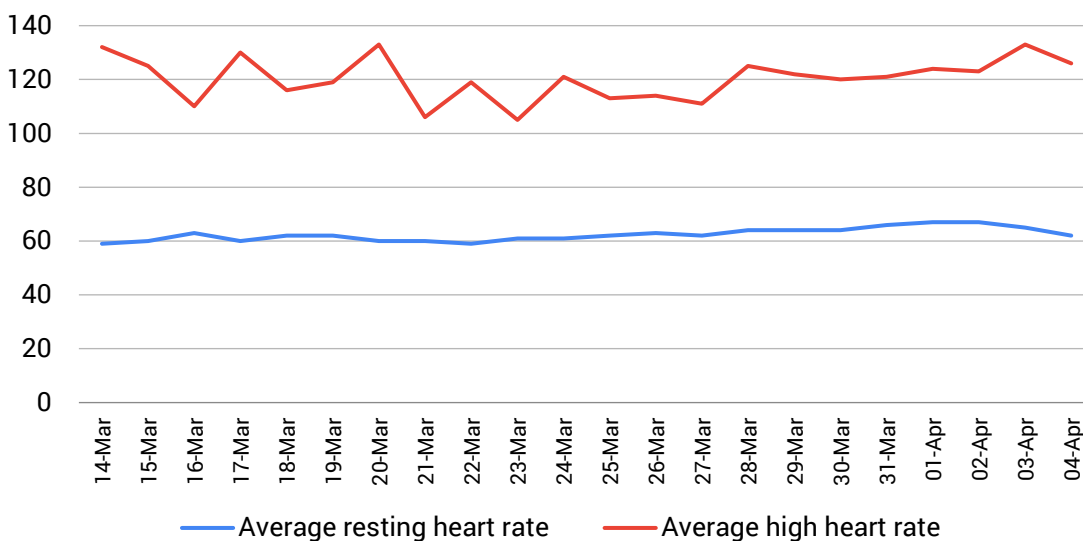


Figure 2: Daily heart rate averages: Resting and high

Sleep

Sleep scores were relatively consistent and healthy throughout the baseline and treatment periods. According to the Centers for Disease Control and Prevention, adults between 18 and 60 should get at least 7 hours of sleep per night (CDC, 2022). Figure 3 shows the amount of total nightly sleep as well as the percentage of that which was spent in deep, light, rapid eye movement (REM), and awake stages. The first seven bars represent the baseline data, with March 21–April 4, 2022, showing the treatment period.

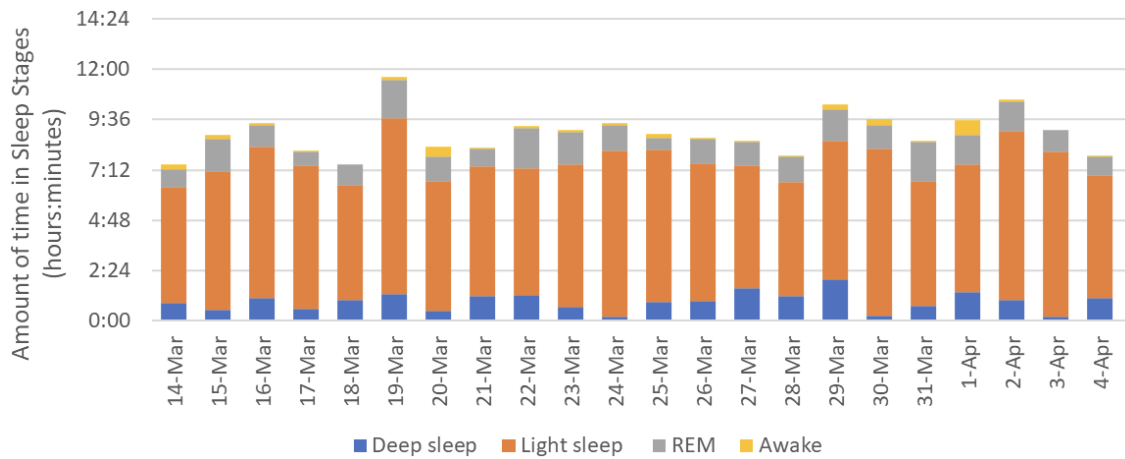


Figure 3: Total sleep and sleep stages

Stress scores

Stress scores were calculated by the Garmin watch using HRV. Levels 25-100 indicate that the sympathetic nervous system is more active than the parasympathetic nervous system, with a higher number reflecting more stress experienced by the body. The daily stress scores in Figure 4 ranged from 22 to 39 did not show any discernible change patterns between baseline and intervention periods. Similarly, in the average weekly scores in Figure 5, the differences seem minimal and do not appear to have any meaningful differences as they are low.

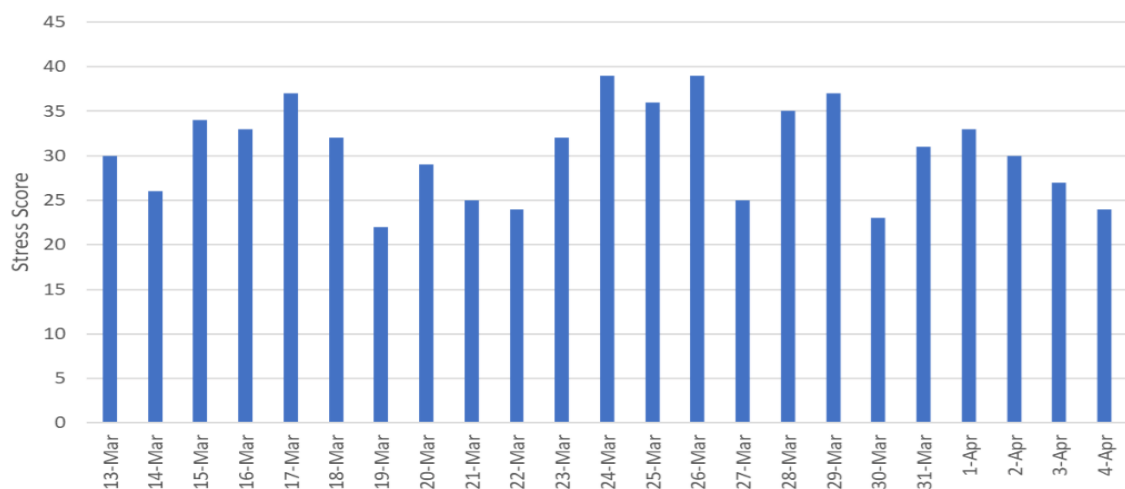


Figure 4: Overall daily stress score

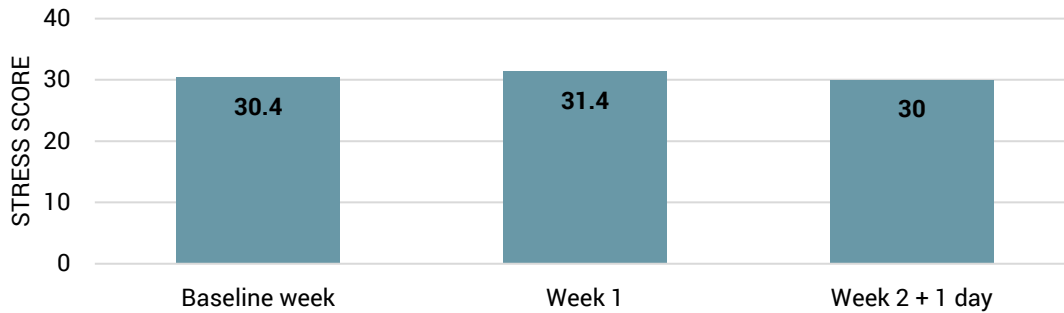


Figure 5: Average weekly stress score

QUALITATIVE FINDINGS

Qualitative findings included three different themes that emerged during phenomenological analysis (Van Manen, 1990): (1) Body awareness and connection; (2) Pain relief; (3) Relaxation, mental clarity, and focus.

Theme 1: Body awareness and connection

Qualitative results showed an increase in the participant's body awareness. Although this was not one of the primary research questions or anticipated outcomes, it emerged as a prominent theme. The following are selected excerpts from the participant's journal emphasising how the low frequency sound treatment increased her body awareness and sense of body connection.

There was an increased awareness around her neck and shoulder area and understanding of how they may be holding her stress:

About two-thirds through, the vibrations were focused around the head and neck. I could feel that this was an area that I hold a lot of stress. It felt so good but also like it couldn't quite let go. It was helpful to be able to pinpoint this area. I knew that I held on to stress in my neck and shoulders, but the chair really emphasised it for me. Post vibes, still seated I feel a little dozy, I feel a warmth and openness in my throat and chest. My face and body feel a slight tingle. I feel relaxed.

Similarly, there was a new awareness of the lighter and more open sensations of the chest and stomach area. It was easier to breathe after the treatment:

I had to rush out, but I feel light in my chest.

Deep breaths feel like less effort, and chest and stomach area feel more open.

Open feeling again in my stomach and chest, deep breaths are very easy.

There was an increased awareness of legs and feet with the participant noting that "legs (calves) are particularly sensitive, almost ticklish to vibrations today."

Theme 2: Pain relief

Pain relief emerged as an unexpected finding, as stated in the following journal excerpts. It seems that lowering anxiety and stress levels may influence a decrease in pain perception. After one of the sessions, the participant stated: "I started today's session with a stress headache and ended the session with no headache!!!" At the beginning of another session, the participant wrote: "cramps are currently uncomfortable, sharp in the right side but manageable (no Advil yet)." However, post-treatment, she wrote: "Cramps are gone!" However, cramps returned about an hour later.

Theme 3: Relaxation, mental clarity and focus

Another consistent theme throughout the treatment period was a feeling of calm, mental clarity, and focus that was reported directly after each treatment. After the first session, the research participant reported "feeling less overwhelm and more clarity." At the beginning of another session, she reported feeling "overwhelmed and worried," but after the session, she wrote: "as I get up and start to walk, I feel relaxed. I am thinking clearly and feel less rushed to get things done today."

The following are also excerpts from the post-treatment journal entries. The research participant declared that she was "feeling relaxed and clear-headed." Another time, she disclosed "feeling calm but not as open in my stomach and chest as other sessions."

The sessions occurred during a hectic time of the participant's life. However, after the treatment, she felt calm, relaxed, lighter, and more focused:

Anxiety is lower now. I was feeling rushed to get a bunch of things done today. Now I'm feeling less rushed, enjoying this moment and where I am post-session.

Felt a little anxious during session about how much I have to do and about being late for everything today and had to rush out but I feel light in my chest and alert.

DISCUSSION AND CONCLUSION

The biological markers examined in this pilot case study included heart rates, amount of sleep, and stress scores measured using HRV. The results indicate that low-frequency sound vibration can have a positive effect on stress and anxiety levels. Post-treatment heart rates were consistently lower by an average of 6.33 beats/minute than the pre-treatment heart rate. The consistency of this result immediately following the treatment suggests that it is significant. However, the daily average resting and high heart rates did not show significant changes. This could indicate that the treatment's effects may be transient, which signals the need for a long-term study. The results could also suggest that low-frequency sound vibration may be beneficial for treating acute, but not chronic, stress and anxiety. However, treating the rapid onset of stress and anxiety may also lead to beneficial long-term results for individuals who experience frequent high anxiety levels. Low-frequency sound vibration may work to both improve and maintain lower anxiety levels. Kärkkäinen and Mitsui (2006) also supported the idea that treating acute stress and anxiety may also lead to beneficial long-term results.

Interestingly, there was no difference between sessions 1-3, which incorporated 30-Hz and 40-Hz frequencies, and sessions 4-6, which used multiple low frequencies; non-predetermined low frequency sounds were experienced as similarly beneficial. A future study could investigate the effects of very low frequencies (e.g., 4-7 Hz or 8-12 Hz) and their potential to increase Theta and Alpha brain waves. Alpha waves are linked with a relaxed, restful, idle brain state, and they are in the frequency range of 8-12 Hz. Theta waves, 4-8 Hz, are linked with a deeply relaxed, 'dream-like' brain state.

Sleep scores were relatively consistent and healthy throughout the baseline and treatment periods. Since there were no significant sleep issues prior to the treatment, it was not easy to gauge whether the treatment could significantly impact sleep patterns. Participants in future studies should include individuals who experience insomnia related to stress and anxiety. Additionally, it will be important to gather more comprehensive sleep data and conduct long-term analyses to assess the effects of low-frequency sound vibration treatments.

Although the results show that low-frequency sound vibration can lower heart rate, indicating an improvement in the stress response, the daily stress scores did not significantly change from the baseline week to the end of the two-week treatment period. However, there were several issues with this particular feature on this device. First, readings were not accurate on days the Garmin Vivosmart 4 device required charging because several hours were not accounted for. The missing data resulted in lower stress scores. The overall stress scores throughout the recorded time were in a healthy range; however, someone with consistently higher stress and anxiety baseline measurements may show a more significant change over time. Another problem was that the stress score was affected by many factors, such as exercise, which is a healthy stress. Therefore, daily activity must be consistent throughout the baseline and treatment time frame for more accurate results to achieve a more accurate overall measurement. Another option would be analysing only the time period directly before, during and after the treatment.

While there were obstacles to overcome with the Garmin Vivosmart 4 device, there were also many benefits. Real-time access to a heart rate monitor was critical for accurately collecting pre- and post-treatment data. It was also very convenient, especially on hectic days, because the Garmin application collected and saved the data for later analysis.

Qualitative data showed increased body awareness and connection, decreased pain and tension, a sense of relaxation, feeling calm, having mental clarity, and focus. Although the study did not set out to specifically examine these categories and the participant was allowed to freely share her feelings, images, and body sensations, they emerged dominantly throughout the treatment process. Interestingly, similar themes were found in previous studies related to Physioacoustic Next Wave chair treatment (Ahonen et al., 2012; Punkanen, 2004) and Somatron (Brodsky, 2000). The decreased anxiety levels may explain the decrease in pain. According to Tang and Gibson (2005), "higher trait anxious individuals tend to exacerbate perceived pain stimulations more than lower trait anxious individuals" (p. 612). "Higher state anxiety (HTA) led to an increase in reported pain intensity for all participants. Furthermore, HTA individuals reported significantly higher levels of anxiety and pain intensity than lower trait anxious (LTA) individuals across all pain and anxiety conditions" (Tang & Gibson, 2005, p. 612). Lowering pain may also result from increased amounts of endorphin or decreased amounts of cortisol in the body. Many studies have investigated music's impact on increasing endorphins

(Blood & Zatorre, 2011; Chanda, 2012; Gangrade, 2012; McKinney et al., 1997) or decreasing cortisol (Bradt & Dileo, 2009; Chanda & Levitin, 2013; Fukui & Yamashita, 2003; Helsing et al., 2016; Khalfa et al., 2003; Kreutz et al., 2004; McKinney et al., 1997; McKinney & Honig, 2017; Mockel et al., 1994). However, there are no studies on the impact of pure low-frequency sound stimulation on these hormones using blood or saliva tests.

The participant was particularly intrigued by the strong sense of calm and mental clarity experienced immediately following treatments. The human brain emanates electrical activity in the form of brainwaves. Two of these frequencies are of particular interest here: alpha and theta. With frequency ranging from 9-14 cycles per second, alpha brainwaves produce reflective, meditative states. Theta brainwaves, which range from 5 to 8 cycles per minute, occur in a free-flow, daydream state that can be connected to creativity and is often a positive mental state (Scientific America, 1997). Results of a 2015 study showed that neurofeedback training with patients with generalised anxiety disorder “caused an increase in alpha and theta brain waves amplitude and is effective in reducing GAD [Generalized Anxiety Disorder] symptoms” (Dadashi et al., 2015, p.19). Therefore, future studies may also benefit from incorporating electroencephalogram (EEG) measurements to examine the effects of low frequency sound vibration on brainwave activity. Including data on the brain, biological markers, bodily sensations, and emotions could offer a more complete picture of the effects of this treatment. In a related study, Physioacoustic Next Wave treatments found similar results of increased concentration, focus, alertness, and clarity, while also helping participants to feel relaxed (Ahonen et al., 2012).

The design of the current study is subject to many limitations. First, the small sample size (one person) reduced the study’s external validity. However, many of the results corresponded with previous research, indicating patterns across various studies that are worth exploring further. Another limitation of the study is the lack of a control group. Optionally, a control group could simply lie down for 20 minutes on the chair without receiving any low-frequency treatment, as was done in the Mosabbir et al.’s (2022) study. In future, a more systematic approach is needed to understand the effect of the vibration in each particular session and how this changes over time. Even if the same programme would be used in all sessions, people respond differently each time and this is impacted by many factors. It would be important to analyse the data so that the results indicate the actual timing of the reactions.

Furthermore, the short length of the study is a limitation. For example, it would be beneficial to have a follow-up after three months and six months. A long-term study, i.e., a 12-week intervention, investigating the effects would also be interesting. Finally, although regularly discussed with the second author who was the research supervisor overseeing the project, the participant/researcher collected the data first-hand, leaving room for subjectivity as is always the case in first-person qualitative studies where the researcher analyses themselves. There can be a tendency to put much hope into a new way of treating or coping with chronic stress and anxiety. This feeling of hope itself may offer some relief. The researcher acknowledges this as a possible bias. Nevertheless, these limitations and learning are helpful when considering the need and direction for further study.

The recommendation is for a long-term study using a sufficiently powered sample size comprising participants who report high levels of stress, anxiety, and insomnia, along with control

groups. It is also recommended that EEG tests be included along with biological markers and qualitative data, such as participant interviews, for a more holistic view. Furthermore, it is recommended to test the impact of certain frequencies.

The results of this pilot case study indicate that whole-body low-frequency sound vibration can positively affect physical, mental, and emotional relaxation. Although low-frequency sound vibration treatments are usually seen as music medicine interventions (Ahonen, 2018), the results about body awareness, connection, relaxation, mental clarity, and focus indicate that low frequency sound vibration could also be a feasible music therapy intervention for clients suffering stress, anxiety, and insomnia. According to Wigram and Crocke (2007), low-frequency sound vibration is a receptive music therapy method. Ahonen's (1996) Psychoauditive Music Therapy method utilises low-frequency sound relaxation during music psychotherapy. Clients received individualised low frequency sound vibration while discussing with the music psychotherapist. Ahonen (1996) also incorporated low-frequency sound vibration stimulation and guided imagery work for music listening thus enhancing body awareness and focus. Further research could explore incorporating low frequency sound vibration into music therapy sessions as a relaxation intervention or aiming to enhance the client's focus. It could be combined with music listening, using the client's preferred music for relaxation, thereafter discussing feelings, images, body sensations, and reflections.

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Μια φαινομενολογική πιλοτική μελέτη περίπτωσης πρώτου προσώπου που διερευνά την αποτελεσματικότητα της χρήσης ηχητικής δόνησης χαμηλής συχνότητας σε ολόκληρο το σώμα για τη θεραπεία του στρες και του άγχους

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ΠΕΡΙΛΗΨΗ

Ο σκοπός αυτής της πιλοτικής μελέτης πρώτου προσώπου ήταν να δοκιμαστεί η χρήση ηχητικής δόνησης χαμηλής συχνότητας σε όλο το σώμα για τη μείωση του στρες και του άγχους, καθώς και να αξιολογηθεί ο υλικοτεχνικός εξοπλισμός που χρησιμοποιείται για τη μέτρηση των επιδράσεων των δονήσεων, με στόχο την ενημέρωση μιας πιο εκτεταμένης, μακροχρόνιας κλινικής μελέτης στο μέλλον. Η φυσικοακουστική καρέκλα Next Wave χρησιμοποιήθηκε για την εφαρμογή των θεραπειών, οι οποίες αποτελούνταν από έξι συνεδρίες 20 λεπτών κατανεμημένες σε διάστημα 15 ημερών. Τα ποιοτικά δεδομένα περιλάμβαναν καθημερινές εγγραφές ημερολογίου, παρατηρήσεις πριν και μετά τη θεραπεία. Μια φαινομενολογική ανάλυση περιελάμβανε τον εντοπισμό αναδυόμενων θεματικών ενοτήτων. Τα ποσοτικά δεδομένα συλλέχθηκαν χρησιμοποιώντας τη συσκευή Garmen Vivosmart 4, η οποία φοριόταν στον καρπό για 24 ώρες καθημερινά (εκτός κατά τη φόρτιση). Η συσκευή μετρούσε τον καρδιακό ρυθμό πριν και μετά τη θεραπεία, τη μεταβλητότητα του καρδιακού ρυθμού (HRV) και την ποιότητα του ύπνου. Μια συνολική βαθμολογία στρες υπολογίστηκε χρησιμοποιώντας τις μετρήσεις HRV και του ύπνου. Τα αποτελέσματα έδειξαν ότι η φυσικοακουστική θεραπεία μπορεί να έχει θετική επίδραση στα επίπεδα στρες και άγχους. Αυτό φάνηκε από τον σταθερά μειωμένο καρδιακό ρυθμό μετά από κάθε θεραπεία, την αυξημένη σωματική επίγνωση και σύνδεση, τη μείωση του πόνου και της έντασης, καθώς και από ένα αίσθημα χαλάρωσης, ηρεμίας, νοητικής διαύγειας και εστίασης. Προτείνονται περαιτέρω μακροχρόνιες μελέτες, χρησιμοποιώντας έναν πιο σημαντικό αριθμό συμμετεχόντων που αναφέρουν υψηλά επίπεδα στρες και άγχους, μαζί με ομάδες ελέγχου. Περαιτέρω μελέτες ενδέχεται επίσης να ωφεληθούν από την ενσωμάτωση μετρήσεων ηλεκτροεγκεφαλογραφήματος (HEΓ) για την εξέταση της δραστηριότητας των εγκεφαλικών κυμάτων, προκειμένου να κατανοήσουμε καλύτερα τα αποτελέσματα που σχετίζονται με το άγχος.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

ήχος χαμηλής συχνότητας, δόνηση, άγχος, στρες

ARTICLE

The effect of patient-initiated rhythmic auditory stimulation on gait speed status post stroke

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ABSTRACT

Rhythmic auditory stimulation (RAS) has been found to be an effective, low-cost, and easily applied intervention for improving gait speed post-stroke. Music-based RAS, the use of auditory rhythmic cues in the form of metrically accentuated music, can result in improved temporal abilities of gait through rhythmic practice. No study has observed the effect of patient-initiated auditory cueing, in conjunction with music-based RAS, on gait speed. Therefore, this study aimed to determine if having the patient initiate an external audible cue, by controlling the timing of their foot adorned with a shoe bell contacting the ground, coordinated with music-based RAS during gait training, will produce further improvement in gait speed. A single-centre randomised pilot study was conducted, consisting of 20 patients with a stroke diagnosis randomised into two groups. The control group ($n = 7$) received music-based RAS using *only music* during gait training, whereas the intervention group ($n = 13$) received music-based RAS using both a *shoe bell and music* during gait training. The 10-m walk test was conducted to determine each participant's pre- and post-intervention preferred and fast gait speed. Preferred speed was the comfortable, naturally chosen speed by the participant, and fast speed was the patient's maximum speed. The t-test showed that there were no statistically significant differences between groups. Paired t-test showed that there were significant improvements in gait speed between pre- and post-test within groups. The inclusion of a shoe bell, in conjunction with music-based RAS during gait training, resulted in a slightly larger improvement in preferred gait speed, whereas music alone during gait training results in a slightly larger improvement in fast gait speed.

KEYWORDS

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INTRODUCTION

Following a stroke, patients may lose their ability to walk normally due to weakness and spasticity affecting the involved side of the body, which is often termed hemiplegic gait (American Stroke Association, 2022). As a result of these physical deficits, stroke leads to a significant decline in gait speed. Gait speed is significantly correlated with disability in patients post-stroke (Tilson et al., 2010). The most frequently stated goal for patients after a stroke is the recovery of gait ability. When stroke patients improve gait speed, they report improved function and reduced disability.

Selecting the optimal approach to enhance gait performance is often a confounding issue for patients and clinicians, since there are so many different interventions for physical deficits post-stroke (Dickstein, 2008). Interventions for improving gait speed post-stroke should be considered in relation to convenience, patient preference, mode of application, and cost. Rhythmic Auditory Stimulation (RAS) is an intervention in which movement is coordinated to sound and has been commonly used in gait rehabilitation for movement disorders (Ghai & Ghai, 2019). This method has been found to be an effective, low-cost, and easily applied intervention for improving gait speed. For instance, research has shown that RAS has medium to large standardised effects to enhance spatiotemporal gait parameters such as gait speed. Ko et al. (2016) have demonstrated increases in gait speed, stride length, step length, and cadence for hemiplegic stroke patients training with various RAS tempos, with greater changes occurring with faster tempos. Specifically with gait, Thaut and Rice (2014) summarises evidence of more attentive and consistent muscle activity during push-off, resulting in faster gait speeds, when RAS is present.

Additionally, for stroke rehabilitation, it is considered best practice that interventions be individually tailored, salient, task-specific, and involve adequate repetition and intensity to induce recovery (Ghai & Ghai, 2019). Training with music-based RAS has the potential to meet these guidelines for post-stroke gait rehabilitation. Music therapy has been found to be a common, as well

as salient, adjunct to treatment for patients during rehabilitation. Music-based RAS, a formalised technique used in Neurologic Music Therapy, can result in improved temporal abilities of gait through rhythmic practice. Music-based RAS consists of a specific protocol aligned with neurological principles and uses auditory rhythmic cues in the form of metrically accentuated music with or without a metronome (Gonzalez-Hoelling et al., 2024).

In healthy older adults, music has been shown to improve gait parameters when compared to a metronome cue (Schaefer, 2014). This finding may be due to the emotional response of music which can motivate continuous rhythmic movement and positively impact gait speed, more so than the production of a precise motor prediction to sound. Music can be easily suited to the patient based on their preference and adjusted throughout gait training with music-based RAS to meet adequate intensity at minimal to no cost.

RAS involves synchronisation processes that are both conscious and unconscious (Schaefer, 2014). Patients tend to react foreseeably to auditory cues once the temporal pattern is mentally 'set up'. Adjustments to the beat pattern occur through conscious effort, which helps fine-tune tempo changes that may occur in the mental representation. In the scenario that music is used during gait training to encourage the mental representation of the gait tempo, the use of an auditory cue on the patient's foot using a shoe bell could help in maintaining the gait speed as the patient would have to adjust their cadence to fine-tune any deviation heard by the shoe bell in comparison to the music. Simply stated, if the patient is still not able to take or maintain a fast enough step with the music over time, the auditory cue of the shoe bell may assist in adjusting their gait speed to maintain the desired tempo, or gait speed.

There is a paucity of research investigating the effect of the patient playing an active role in initiating an auditory cue in conjunction with music-based RAS on gait speed. In prior studies, music played by the music therapist, was the only stimulation used and adjusted to facilitate a change in gait parameters, such as speed. Therefore, this randomised prospective pilot study from a single centre aimed to determine if having the patient initiate an external audible cue, by controlling the timing of their foot adorned with a shoe bell contacting the ground, in sync with music-based RAS during gait training would produce further improvement in gait speed. This intervention differs from prior studies in that the patient is producing an additional external auditory cue to match the tempo change in music to achieve a change in gait parameters. It was hypothesised that patients would demonstrate a more consistent volitional reaction to their own production of sound with each step taken in concurrence with the tempo of the music and, therefore, show a further increase in gait speed.

MATERIAL AND METHODS

Participants

This study was approved by Memorial Healthcare System's Internal Review Board (IRB #MHS.2022.047). Informed consent was obtained from all participants prior to enrolment and initial assessment, as required for the protection of human participants. Consent forms included details on the purpose of the study, benefits and risks of participation, voluntary right to participate and withdraw, and confidentiality of records and data sharing. Authorisation to release protected health information was also requested as part of the informed consent.

Design

A pilot randomised prospective study was conducted to determine if music-based RAS with music and shoe bell during gait training impacted preferred, or comfortable gait speed, and fast, or maximum, gait speeds. Primary eligibility criteria for the study included: stroke diagnosis, age 18 years or older, adequate hearing, intact capacity to follow simple commands, and the ability to ambulate 10 meters on initial assessment. Initially, a sample size of 30 was chosen based on the number of strokes admitted to the study facility per year and likelihood of ability to ambulate the minimal 10 meters on admission. However, due to staffing changes and time constraints, only 20 patients were enrolled and completed the study. Using a computer-generated randomisation schedule, a total of 20 patients with a stroke diagnosis were randomly assigned to the control or intervention group. Based on the computer-generated randomisation, seven patients were placed in the control group and thirteen patients were placed in the intervention group by the end of subject recruitment. The control group received music-based RAS using *only music* during gait training, whereas the intervention group received music-based RAS using both *a shoe bell and music* during gait training.

Procedures

Prior to the interventions, the research investigator, who was masked to the randomisation, conducted a 10-m walk test to determine each participant's baseline gait speeds. The 10-m walk test was used to assess gait speed in meters per second over a 10-m distance (Shirly Ryan Ability Lab, 2014). The participant walks without assistance for 10 meters, with the time measured for the middle six meters to allow for acceleration and deceleration. Either preferred gait speed or fast gait speed can be tested (Shirly Ryan Ability Lab, 2014). Preferred gait speed is the participant's comfortable, natural walking speed, while fast gait speed is the maximum walking speed of the participant. For preferred gait speed, the participants were asked to walk the 10-m distance at their comfortable, natural pace. When assessing fast gait speed, participants were asked to walk as fast, but safely, as they could for the 10-m distance. An average of two trials was computed to measure preferred and maximum gait speed. Assistive devices may or may not be used but must be kept consistent and documented for each measure of performance. For the stroke population, the 10-m walk test has excellent test-retest reliability ($ICC = 0.95$ to 0.99) and strong correlation with dependence in instrumental activities of daily living ($r = .76$; Shirly Ryan Ability Lab, 2014).

During each session, music-based RAS was conducted with music set at the recommended one to three beats per second above the patient's baseline gait speed (Ghai & Ghai, 2019). Music consisted of played guitar chords synced to a metronome monitored and adjusted by the Neurologic Music Therapist providing treatment. Chords played were based on the song and genre preference of each patient. For patients in the intervention group, a shoe bell was strapped around the patient's foot of the involved lower limb as shown in Figure 1. The intervention lasted a total of 20-minutes per session, not including seated rest breaks. A total of six treatment sessions were provided during the patient's rehabilitation stay (three times per week for two weeks). Following the sixth session, the 10-m walk test was repeated to determine the patient's post-intervention preferred and fast gait speeds. The

collection of all data was conducted by a separate recorder that was not involved in the intervention, randomisation of subjects, or assessment of the outcome measures.

STATISTICAL ANALYSIS

Descriptive statistics were calculated for all demographic variables. Fisher's Exact Test was used to examine categorical variables with results presented as counts and proportions. Welch's *t*-test was used to assess continuous variables for between group differences (i.e., control vs. intervention group mean differences). To assess the study's outcome measure of within group mean difference in gait speeds, pre- and post-intervention, a paired sample *t*-test was used. Results of continuous variables are presented as mean and standard deviation (SD), as well as range. Results were considered statistically significant at a significance level of $p < .05$. All analyses were conducted using Stata/SE 15.1.



Figure 1: Shoe bell donned to the foot of the involved limb

RESULTS

A total of 20 patients met the study's inclusion criteria, of whom 65% ($n = 13$) were randomised to the intervention group. Age ranges for each group included minimum to maximum values. The average age among the control group (music only) was approximately 59 years old, while the average age among the intervention group (music with shoe bell) was almost 65 years old. There were no statistically significant differences in demographic characteristics between the control and intervention group, as shown in Table 1.¹ All participants were patients admitted into inpatient rehabilitation in the early subacute phase, which is an average of seven to ninety days post their initial onset of stroke.

In the assessment of between-group mean differences for preferred gait and fast gait speeds, there were no statistically significant differences between the control and intervention groups as demonstrated in Table 2. However, in the assessment of within group pre-to-post mean differences, there were statistically significant increases in preferred and fast gait speeds, pre-to-post interventions for both the control and intervention groups. Although both groups had significant increases in preferred and fast gait speeds, on average, the intervention group had a slightly larger increase in preferred gait speed compared to the control group (0.5 vs. 0.4 m/s) and the control group had a slightly larger increase in fast gait speed compared to the intervention group (0.7 vs. 0.6 m/s) as demonstrated in Table 3.

¹ Note for Tables 1, 2 and 3: Boldface font indicates statistical significance at $p < .05$. Note: Rounding errors may be present.

	Music only (%)	Music with shoe bell (%)	p-Value
N (%)	7 (35.0)	13 (65.0)	-
Age in years			
Mean ± SD	59.3 ± 6.0	64.9 ± 15.7	.266
Range	52 - 68	26 - 91	-
Gender			1.000
Male	4 (57.1)	7 (53.8)	
Female	3 (42.9)	6 (46.2)	
Race/Ethnicity			.718
NH White	2 (28.6)	4 (30.8)	
NH Black	3 (42.9)	6 (46.2)	
NH Other	1 (14.3)	0 (0.0)	
Hispanic	1 (14.3)	3 (23.1)	

Table 1: Participant demographics, by intervention type

Abbreviations: SD, Standard Deviation; NH, Non-Hispanic

	Music only, Mean ± SD	Music with shoe bell, Mean ± SD	Absolute mean difference	p-Value ^a
Preferred Gait (m/s)				
Pre-Intervention	0.4 ± 0.3	0.4 ± 0.2	0.0	.814
Post-Intervention	0.8 ± 0.4	0.9 ± 0.4	0.0	.835
Fast Gait (m/s)				
Pre-Intervention	0.6 ± 0.4	0.7 ± 0.3	0.1	.570
Post-Intervention	1.3 ± 0.6	1.2 ± 0.4	0.0	.912

Table 2: Gait speed between group absolute mean differences

^a p-Values indicate statistical significance of mean differences *between* the control (music only) and intervention (music with shoe bell)

Gait Speed (m/s)	Music only, N= 7				Music with shoe bell, N=13			
	Pre Mean	Post Mean	Absolute Mean Difference	p-Value ^a	Pre Mean	Post Mean	Absolute Mean Difference	p-Value ^a
Preferred Gait	0.4	0.8	0.4	0.004	0.4	0.9	0.5	<0.001
Fast Gait	0.6	1.3	0.7	0.002	0.7	1.2	0.6	<0.001

Table 3: Gait speed within group pre- and post-intervention mean differences

^a p-Values indicate statistical significance of differences between the pre and post periods *within* each group

DISCUSSION

Overall, there was no statistically significant difference between the control and intervention groups. Within each group, there was a significant difference in the improvement of preferred and fast gait speed. Specifically, the control group, which had only music, had a slightly *larger* improvement in *fast* gait speed. This result could be due to the control group having no cognitive loading factor, or need to dual task synchronising the sound of shoe bell with music. However, the intervention group with music and shoe bell had a slightly *larger* improvement in *preferred* gait speed. In other words, a slightly larger change in preferred, natural gait speed occurred in participants in the intervention group. Based on this finding within the intervention group, a question arises of whether or not there was an internal neuroplastic adjustment of the patients' physiological and spatial settings for preferred gait speed.

There are multiple studies that provide evidence of the ability of RAS to induce neural entrainment of auditory, sensorimotor, and motor pathways of the brain resulting in significant functional and structural brain changes, especially in motor regions (Braun Janzen et al., 2022; Ghai & Ghai, 2019). Hutchinson et al. (2020) showed that an immediate change in preferred and fast walking speeds occurred after only a single bout of training, with additional increases following three days of training. Also, positive benefits of training with RAS have been shown to persist after six months of intervention in community-dwelling older adults (Shirly Ryan Ability Lab, 2014). However, more research is needed on retention of gains once training is stopped.

Numerous factors contribute to our preferred gait speed including the aforementioned neurological control, joint range of motion, limb strength, sensory function, cognitive status, and energy level (Chui et al., 2020). Collimore et al. (2023) observed a reduction in the energy cost of walking following RAS with gait training in post-stroke patients. The mechanism by which the shoe bell could have specifically affected these individual factors will need further investigation. Regarding joint range of motion and limb strength, a question arises of whether the shoe bell may have facilitated more intentional ankle movement and muscle force of the limb by the patient to produce a synchronised bell ring with the music. As far as sensory function, additional questions arise pertaining to whether or not the bell may give feedback of foot placement for patients who lack sensory information of the affected limb. In other words, did the sound of the bell enhance coordination, timing, and initiation of the affected limb to increase speed? Although cognitive loading likely contributed to the fast gait speed being slightly lower within the intervention group compared to the control group, could the attention required to synchronise the bell sound with music increase the attention to initiate a step more quickly during the slower preferred gait speeds? Shaefer (2014) reviews that tasks performed with auditory rhythmic cues lessen the requirement of motivational and attentional efforts directed towards timing and motor control, with an enhancement in emotional engagement. With these contributing factors being enhanced, gait spatiotemporal parameters such as cadence and stride length, and ultimately velocity, will also improve and lead to a more efficient gait pattern which plays a significant role in our selected preferred gait speed (Chui et al., 2020).

Last, is fast or preferred gait speed more important to monitor during the recovery of stroke patients? Based on past study results, preferred gait speed should be considered for predicting physical function and chronic diseases, while fast gait speed helps in estimating subjective general health and muscle mass gains (Kim et al., 2016). Therefore, fast gait speed is a stronger predictor

of disability onset, while preferred gait speed is a highly reliable indicator of health and functional ability in older adults (Mehmet et al., 2020). Moreover, during post-acute stroke, fast gait speed would be considered favourable to monitor for the severity of disability caused, whereas in the subacute to chronic stage, preferred gait speed is essential in determining maintenance of function versus decline from a possible regression due to progression of initial stroke or reoccurring stroke. All the factors discussed could guide the choice of whether to use a shoe bell in addition to music during RAS training versus music alone. For example, if a patient is within the subacute stage post-stroke and exhibits sensory deficits, decreased motivation and/or attention, and has minimal cognitive deficits, utilising music-based RAS in conjunction with a shoe bell may slightly improve their preferred walking speed while also engaging the patient and allowing insight into their current physical function and health.

CONCLUSION

Music-based RAS with only music and music-based RAS with music and shoe bell resulted in statistically significant improvement of both preferred and fast gait speeds, when comparing pre-post intervention. There were no statistically significant differences between the two groups; however, a slightly larger improvement in preferred gait speed was observed in the music-based RAS with music and shoe bell group. Therefore, using a shoe bell in addition to music versus music alone during music-based RAS may show a slightly larger improvement in preferred gait speed across time for individual patients. Contrary to the hypothesis of the shoe bell resulting in globally faster gait speeds when compared to music alone, gait training with music only was shown to result in a slightly larger improvement in fast gait speed across time for individual patients.

The results of this study are limited due to the small sample size and further research is needed to confirm findings. Other potential topics for future studies may include how a shoe bell impacts the factors that determine preferred gait speed along with the impact a shoe bell has on attention to limb advancement during preferred gait speed. Cognitive loading limitation should be considered when assessing fast gait speed, particularly for patients with cognitive deficits. Choosing whether to use a shoe bell in conjunction with music versus music alone, should be guided by the patient's stage of recovery post-stroke and cognitive ability.

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Ελληνική περίληψη | Greek abstract

Η επίδραση της ρυθμικής ακουστικής διέγερσης με πρωτοβουλία του ασθενούς στην ταχύτητα βάδισης μετά από εγκεφαλικό επεισόδιο

Karen Lanier | Shenae Samuels | Trenton Barrick | Valerie Killoran | Rachel Woolley

ΠΕΡΙΛΗΨΗ

Η ρυθμική ακουστική διέγερση (rhythmic auditory stimulation, RAS) έχει αποδειχτεί ότι είναι μία αποτελεσματική, χαμηλού κόστους και εύκολα εφαρμόσιμη παρέμβαση για τη βελτίωση της ταχύτητας βάδισης μετά από εγκεφαλικό επεισόδιο. Η βασισμένη-στη-μουσική RAS, δηλαδή η χρήση ακουστικών ρυθμικών σημάτων με τη μορφή μετρικά τονισμένης μουσικής, μπορεί να οδηγήσει σε βελτιωμένες χρονικές ικανότητες βάδισης μέσω ρυθμικής εξάσκησης. Σε καμία έρευνα δεν έχει μελετηθεί η επίδραση των ακουστικών σημάτων με πρωτοβουλία του ασθενούς, σε συνδυασμό με τη βασισμένη-στη-μουσική RAS, στην ταχύτητα της βάδισης. Ως εκ τούτου, η παρούσα μελέτη είχε στόχο να προσδιορίσει αν η παροχή ενός εξωτερικού ακουστικού σήματος από τον ασθενή, ο οποίος ελέγχει τον χρονισμό επαφής του ποδιού του με το έδαφος, καθώς φοράει παπούτσι με κουδούνι, συντονισμένα με βασισμένη-στη-μουσική RAS κατά τη διάρκεια εξάσκησης της βάδισης, μπορεί να επιφέρει περαιτέρω βελτίωση στην ταχύτητα της βάδισης. Πραγματοποιήθηκε μία μονοκεντρική τυχαιοποιημένη πιλοτική μελέτη, με 20 ασθενείς με διάγνωση εγκεφαλικού επεισοδίου οι οποίοι τυχαιοποιήθηκαν σε δύο ομάδες. Η ομάδα ελέγχου (n=7) έλαβε βασισμένη-στη-μουσική RAS μόνο με χρήση μουσικής κατά την εξάσκηση της βάδισης, ενώ η ομάδα παρέμβασης (n=13) έλαβε βασισμένη-στη-μουσική RAS με χρήση παπουτσιού με κουδούνι και μουσική κατά την εξάσκηση της

βάδισης. Διεξήχθη η δοκιμασία βάδισης των 10 μέτρων για να προσδιοριστούν η προτιμώμενη ταχύτητα και η γρήγορη ταχύτητα βάδισης κάθε ασθενούς πριν και μετά την παρέμβαση. Κατά την αξιολόγηση των μέσων διαφορών μεταξύ των δύο ομάδων για την προτιμώμενη ταχύτητα και τη γρήγορη ταχύτητα βάδισης, δεν βρέθηκαν στατιστικά σημαντικές διαφορές μεταξύ των ομάδων ελέγχου και παρέμβασης. Κατά την αξιολόγηση των μέσων διαφορών εντός των ομάδων πριν και μετά την παρέμβαση, υπήρξε στατιστικά σημαντική αύξηση ως προς τις προτιμώμενες ταχύτητες και τις γρήγορες ταχύτητες βάδισης, πριν και μετά την παρέμβαση. Η προσθήκη ενός κουδουνιού στο παπούτσι, σε συνδυασμό με τη βασισμένη-στη-μουσική RAS κατά τη διάρκεια της εξάσκησης της βάδισης, είχε ως αποτέλεσμα μία ελαφρώς μεγαλύτερη βελτίωση στην προτιμώμενη ταχύτητα βάδισης, ενώ μόνο η μουσική κατά την διάρκεια της εξάσκησης της βάδισης οδήγησε σε ελαφρώς μεγαλύτερη βελτίωση στην γρήγορη ταχύτητα βάδισης.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

εγκεφαλικό επεισόδιο, ταχύτητα βάδισης, μουσικοθεραπεία

ARTICLE

Music-centred psychotherapy for adults with mood and anxiety disorders: A programme evaluation

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ABSTRACT

This paper outlines the creation and programme evaluation of a music therapy group for adults within an inpatient mood and anxiety disorder treatment programme in Southwestern Ontario, Canada. The author first discusses the process involved in programme development and facilitation of a four-session closed group framework of resource-oriented and music-centred psychotherapy. The author then presents the results from a programme evaluation that included 154 patients, elucidating lived experiences from the music therapy group. Quantitative results trace patients' perceptions of music therapy's impact within the domains of mood, anxiety, interpersonal connections, expression, and musical resource development. Qualitative themes explore patients' experiences in music therapy in the areas of lightness and depth, interpersonal connections, relationships to music, and trying something new. Patients' lived experiences and perceptions of the group's impact validate that music therapy can invite in-depth therapeutic process while also developing and celebrating patients' resourceful use of music in their everyday lives.

KEYWORDS

music psychotherapy,
programme
evaluation,
depression,
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INTRODUCTION

I was hired in 2017 to develop a music therapy programme at an adult mental health facility in Southwestern Ontario, Canada, that had not previously employed a music therapist. Aiming to create programming that was responsive to patients' needs and that would exist sustainably and symbiotically within the complex organism of the facility, I began by learning about the facility's existing programmes, observing groups and meeting with clinicians and managers. Within the institution's varied treatment units, most patients had busy schedules, attending a wide variety of

psychotherapeutic, psychoeducational, and recreational sessions. Programme development involved advocating for music therapy's role in mental health recovery while also respecting the value of existing programming and the busy nature of patients' lives while admitted for treatment.

This paper explores the creation and evaluation of a music-centred psychotherapy group for adults with mood and anxiety disorders seeking treatment at this facility. Though this programme evaluation was initially intended to provide data for the facility, this paper's elucidation of the results of programme evaluation contributes to the literature exploring music therapy's impact within mental health treatment. In addition, through discussion of the process involved in developing and facilitating clinical programming within a four-session closed group framework, it is my intention to provide a resource for practitioners. As inpatient admissions within mental health settings decrease in duration (Newman et al., 2018), and yet many people struggle to access mental health care in their communities (Canadian Institute for Health Information, 2023), it is imperative that clinicians create frameworks for brief service provision that invite in-depth therapeutic process while also developing patients' resourceful use of music in their everyday lives (Rolvjord, 2010).

I use the term "patients" throughout this paper to describe those with whom I worked in the context of this group. This term is the norm at this facility, which speaks to the facility's overall promotion of a medical model of treatment. I use the term "experience," rather than "intervention," to describe the various musical happenings within sessions. As Rolvsjord (2010) points out, the term intervention "implies a discourse in which the therapist's actions are regarded as more important in relation to the outcome of therapy than the client's, thus preserving the traditional patriarchal power relation" (p. 23). Resource-oriented practice involves "collaboration rather than intervention" (p. 74), a value-system that I seek to bring to my work. "Music-centered psychotherapy" is defined by Bruscia (1998) as work wherein

[...] the therapeutic issue is accessed, worked through, and resolved through creating or listening to music; verbal discourse is used to guide, interpret, or enhance the music experience and its relevance to the client and therapeutic process. (Bruscia, 1998, pp. 2-3)

In using this term, I am drawing upon Bruscia's definition while also deliberately working within the tensions and even contradictions that can exist between music-centred versus psychotherapeutic practice (Aigen, 2014), tensions that I will return to in the Discussion section.

In the section that follows, I provide an overview of some foundational and current literature surrounding music therapy's role in mental health treatment.

LITERATURE REVIEW

Music therapy and mental health: Historically speaking

That music can play a role in mental health treatment has been an integral part of the evolution of the music therapy profession. For example, musicians visited hospitals following World War Two to play for veterans recovering from the devastating impacts of war, both physical and emotional. The American Music Therapy Association (2022) noted:

patients' notable physical and emotional responses to music led the doctors and nurses to request the hiring of musicians by the hospitals. It was soon evident that the hospital musicians needed some prior training before entering the facility and so the demand grew for a college curriculum. ("History of Music Therapy", para. 1)

Ansdell (2002) recounted a similar development in the U.K., reflecting that "musicians played to, but increasingly also with patients," leading to the "development of the modern discipline and profession of Music Therapy" ("Towards Music Therapy", para. 3).

In North America, Ira Altshuler was a psychiatrist in Detroit who in 1938 initiated one of the first large-scale music therapy programmes for individuals hospitalised for mental illness (Davis, 2003). Florence Tyson practiced in psychiatric hospitals in the 1950s, and in 1962 founded the Creative Arts Rehabilitation Center in New York City (Florence Tyson Fund, 2012). Norma Sharpe was a crucial founder of music therapy practice in Canada. In the 1950s she began working at the psychiatric hospital in St. Thomas, Ontario, which is now closed (Kruger, 2023).

Music therapy for depression and anxiety

A systematic review of music therapy and depression (Aalbers et al., 2017) assessed the effect of music therapy upon depression based on nine studies. These studies were varied in terms of their design and approach to music therapy, and they did not all indicate whether a trained music therapist had been present, making it challenging to generalise based upon the results. Nonetheless, the review found that music therapy provides "short-term beneficial effects for people with depression" and "shows efficacy in decreasing anxiety levels and improving functioning of depressed individuals" (p. 2). Lu et al. (2021) conducted a meta-analysis that included 32 randomised controlled trials in order to evaluate the efficacy of music therapy on anxiety. They found that music therapy can lead to significant improvement in anxiety symptoms during treatment (Abstract), but that further research is required to determine lasting effects.

Relevant to the current paper, research has demonstrated the efficacy of improvisation in music therapy for targeting symptoms of depression and anxiety. For example, Erkkilä et al. (2011) found that individual improvisational music therapy resulted in significant improvements in depression and anxiety symptoms. Zarate (2016) investigated the impact of individual music and vocal psychotherapy upon anxiety. Her research produced statistically significant changes in clinical anxiety symptoms. Though mild and moderate anxiety symptoms remained after music therapy, "severe symptoms disappeared by the last session, which would suggest improved everyday functioning and management of anxiety symptoms" (p. 49).

A substantial body of qualitative research regarding music therapy's impact in mental health settings amplifies service users' voices and experiences. Ansdell and Meehan (2010) conducted research with clients deemed "treatment-resistant" by the medical system. Their findings support music therapy's role in assisting patients to re-establish the use of music as a "health-promoting resource and coping strategy" (p. 29). McCaffrey (2018) interviewed six mental health service users who found music therapy to be occupying, stress-relieving, and flexible, while also fostering reciprocity when undertaken in a group setting. Solli et al. (2013) conducted a qualitative meta-synthesis of

14 studies examining 113 clients' experiences in music therapy. Their study noted four overall areas of experience for clients in music therapy: "having a good time," "being together," "feeling," and "being someone" (p. 254). In not placing focus upon music therapy's role in symptom reduction, these studies align with a "recovery-oriented" perspective. Without denying the importance of symptom reduction, recovery-oriented practice recognises and focuses upon factors that contribute to living a "satisfying, hopeful, and contributing life even with limitations caused by illness" (Anthony, 1993, p. 15), highlighting self-determination, empowerment, social inclusion, meaningful activity, and resources (McCaffrey et al., 2011; Solli et al., 2013). From this perspective, musical involvement may provide "opportunities, resources, and support for members to demonstrate and perform their wellbeing and recovery" (Ansdell & DeNora, 2016, p. 148).

Jackson (2012) noted that there is minimal music therapy research that focuses specifically upon individuals diagnosed with depression and anxiety. She also stated that much of the existing literature concerns the use of receptive music therapy methods, rather than more active and creative approaches. The current paper assists in filling this gap in the literature.

THE CLINICAL WORK: CONTEXT AND CONTENT

The patients referred to in this paper were 18 years of age or older, and enrolled in an eight-week, group-based, inpatient treatment programme for mood and/or anxiety disorders. As the programme is voluntary, most patients were motivated to attend. Facility programme data from 2016 indicates that the mean age of patients in this programme is 42 years, and 44% of patients identify as male. As the programme is not publicly funded, patients are largely working professionals with insurance benefits, and/or individuals of middle to high socio-economic status. Many patients concurrently receive electroconvulsive therapy. Music therapy took place in a closed group format in which groups of typically six to eight patients attended four 90-minute sessions: two per week for two weeks. All patients admitted to the mood and anxiety disorders programme attended the four sessions of music therapy unless there was a clinical counterindication as decided upon by the interdisciplinary team. Sessions during the period described in this paper were either facilitated by me alone or co-facilitated by me and a music therapy intern.

Clinical approach

My facilitation of this group drew upon a resource-oriented approach to music-centred psychotherapy. Music-centred music therapy recognises that "music enriches human life in unique ways" and thus is "a legitimate focus of the work of music therapists" (Aigen, 2014, p. 65). I view the music-making that occurs within music therapy to be "continuous with its engagement in nonclinical contexts" (p. 156). This lens gives the therapist permission to focus upon "making music possible" (Stige, 2010, p. 16), rather than focusing solely upon nonmusical outcomes. In addition to holding a strong philosophical alignment with music-centred perspectives, I am also a Registered Psychotherapist in Ontario. As such, I hold an eclectic perspective upon music therapy and draw upon both music-centred and psychotherapeutic theories in my practice.

I am also influenced by resource-oriented music therapy. Rolvsjord (2010) describes that a resource-oriented approach “involves the nurturing of strengths, resources, and potentials”; “involves collaboration rather than intervention”; “views the individual within their context”; and finally, views “music... as a resource” (p. 74). This approach validates the importance of music in human life and strives to understand and work with the musical strategies that people use naturally to improve wellbeing (DeNora, 2000; Ruud, 2013).

Goals and a four-session framework

Goals for music therapy were somewhat flexible based upon the needs of each cohort, but generally reflected the following domains: to identify, regulate, and express emotions; to develop personalised musical resources; to explore and enhance self-identity; to connect/reconnect with music and creativity; and finally, to enhance community and mutual support. These goals reflected typical clinical needs of the patients as well as my music-centred perspective upon the importance of musical engagement and the unique affordances of such engagement. To facilitate working towards these goals within the allocated four sessions, the interns and I developed a framework for the sessions in which we endeavoured to balance providing a consistent experience from cohort-to-cohort with remaining flexible to meet the unique needs of specific groups.

The first session started with group discussion about people’s pre-existing relationships to music, demonstrating my commitment to validating people’s knowledge about music’s use as a “self-help technology” (Ruud, 2013, para. 4). At times there were patients who had extensive formal musical training/experience, but most patients recounted relationships to music that primarily involved regular music listening, having not played an instrument or sung since being in school. We discussed the ways in which the use of music in therapy is connected to our use of music in our day-to-day lives. After this initial discussion, most sessions were primarily comprised of improvisation and listening. The music therapy space was equipped with pitched and unpitched percussion instruments, in addition to an acoustic piano and two guitars. During improvisations, the music therapist alternated between providing a harmonic framework from the piano or guitar, versus supporting patients’ music-making from a percussion instrument.

To introduce improvisation, the group started with structured experiences in which patients each created one repetitive pattern on an instrument, and gradually combined their sounds together; this facilitated co-listening while fostering containment, given the music’s predictable nature. Based upon patients’ comfort and responsiveness, I gradually introduced experiences that afforded more creativity, always allowing patients to control when to let go of the structure. I also typically provided less rhythmic stability in the music-making as sessions progressed, constantly assessing whether patients were able to tolerate the increased uncertainty, and at times messiness, that comes with less rhythmic structure. As individuals gained familiarity with improvisation, they explored the balance between sharing their voices while responding to the contributions of others.

We also often engaged in referential improvisations based upon images and emotions suggested by patients or by the music therapist. An image that I often suggested was that of a storm, explaining to patients that we would strive to co-create music that moved from calmness, to intensity, and back to calmness. Clinically, the experience provided an opportunity for expression and regulation

of emotions, moving through the build to loudness and even chaos, and then feeling the music's subsequent settling. Some groups of patients discussed the storm's direct connection to their lives and their emotions. For others, the storm did not represent their storm and the experience afforded symbolic distance (Ahonen, 2016). For others still, the experience offered the opportunity to make creative decisions to further a musical goal.

In addition to improvisation, each patient shared one piece of music that had played a meaningful role in their life. Patients shared about their music's significance; we then listened and reflected as a group. I introduced intentional playlist creation, starting by exploring the ways that playlists can capture a unified mood. I then introduced the concept of the iso-principle, and its relation to music listening (Heiderscheit & Madson, 2015). We discussed the role of emotional validation prior to attempting to change one's mood, and patients created their own iso-principle playlists to share at the final session. My approach to this content was at times more didactic in nature, particularly with patients for whom the concept of intentional playlists was unfamiliar; however, themes and songs for playlists were always selected by patients. Having described the four-session framework, I will move now to a discussion of the programme evaluation process.

PROGRAMME EVALUATION

This project received Research Ethics Board approval at the mental health facility, and also at Wilfrid Laurier University, for the use of this programme evaluation data for research purposes. Programme evaluation is typically undertaken to "produce information about the performance of a programme in achieving its objectives" (Grembowski, 2001, p. 3). Such evaluations apply research methods to answer questions as to whether and why a programme is "working as intended" and to "increase the accuracy and objectivity of judgements about the program's success" (p. 3). Grembowski portrays the programme evaluation as a three-act play. First, evaluators "define the questions that the evaluation will answer about a program"; then, they apply research methods to "answer the questions raised in Act I"; finally, "answers to the evaluation and policy questions provide insights that influence decision making and policy" (p. 16). In this section, I will outline the processes involved in Acts I and II, that is, the creation and implementation of a programme evaluation tool for this music therapy group.

Defining the questions

As music therapy was a new offering at the facility, I was invested in generating data to better understand patient experience. Thus, this programme evaluation set out to answer the broad question: What is the nature of patients' experiences of group music therapy within the mood and anxiety disorder treatment program? This group was an ideal setting within which to implement an evaluation process given the group's structure, wherein all patients attended four sessions that were similar in their content across each cohort of patients.

Specifically, I was interested in exploring patients' perceptions of music therapy's effectiveness in the following areas: mood elevation, anxiety reduction, connection with others, musical resource development, and emotional expression. As programme evaluations are inevitably connected to evaluators' values, it is vital to make my values explicit, so that "those for whom the evaluation is

intended [are made] aware of the value system that has undergirded the evaluation” (Owen, 2020, p. 10). The questions posed on the evaluation form are connected to my orientation as a music psychotherapist and to my theoretical leanings towards music-centred and resource-oriented practice. I hold a constructivist epistemology. I recognise that individuals “develop subjective meanings of their experiences” and that “these meanings are varied and multiple” (Cresswell, 2014, p. 8). Thus, I chose to solicit narrative feedback, in addition to numerical data, in order to understand patients’ subjective experiences more fully. The process involved in data gathering will be described next.

Undertaking the evaluation

After devising the questions, the next step in programme evaluation is to apply research methods to answer these questions. The design of this questionnaire drew upon a “convergent parallel mixed methods design” (Cresswell, 2014, p. 219), in which quantitative and qualitative data are collected and analysed separately. The results are then compared, with the assumption that the combination of approaches “provides a more complete understanding of a research problem than either approach alone” (p. 4).

I devised a simple questionnaire (see Appendix 1) that patients had the option to complete at the end of the fourth session. Patients were informed that filling out this form was voluntary, and that data would remain anonymous. Those patients who chose to fill out this form did so independently, while the music therapist either stepped out of the room or began to pack up instruments in a separate area. Of the 311 patients who attended this group between June 2017 and April 2019, 154 chose to fill out this form and their data is included here. The programme evaluation form asked patients to self-report in the following areas using 5-point Likert scales: 1) This group helped to elevate my mood; 2) This group helped to reduce my anxiety; 3) This group helped me to connect with my co-patients; 4) I learned ways I can use music to cope in my life; and 5) I found ways to express myself through music. These individual data points were used to calculate mean, median, and standard deviation.

Next, the form asked patients the following open-ended questions: 1) What did you find useful/helpful about the program? 2) What recommendations would you make for the programme going forward? and 3) Is there anything you wish to see changed based on your experiences? A Research Assistant and I independently conducted thematic analysis (Braun & Clarke, 2006) on patients’ narrative responses using first and second cycle techniques (Saldaña, 2013). All themes and topics present in patients’ responses were noted, and then these were gradually collapsed into a smaller number of main categories as the interrelationships between the codes became apparent. Recognising the interpretive nature of any coding process, I strove to remain open to the emergent themes by ensuring similitude between my analysis and the Research Assistant’s, and by re-reading each patient’s responses multiple times.

RESULTS

Returning now to Grembowski’s (2001) conceptualisation of programme evaluation as a three-act play, the following section explores the third act, that is, the patients’ responses.

Mean, median, and standard deviations derived from the Likert scale data are displayed in Table 1. The Likert scales consisted of 5 possible points, where 5 represented “a lot”, 4 represented “quite a bit”, 3 represented “somewhat”, 2 represented “a little bit”, and 1 represented “not at all”. These results display that most patients found the group “quite a bit” helpful in each of the domains.

Evaluation item	Mean	Median	SD
This group helped to elevate my mood	4.3	5	0.83
This group helped to reduce my anxiety	3.9	4	1.12
This group helped me to connect with my co-patients	4.3	5	0.82
I learned ways I can use music to cope in my life	4.3	5	0.87
I found ways to express myself through music	4.2	4	0.89

Table 1: Results from Likert-scale evaluative items

Five main categories emerged through qualitative coding, providing a perspective upon patients’ overall experiences in music therapy: lightness and depth, interpersonal connections, relationship to music, trying something new, and practicalities. These categories, along with their themes and sub-themes, are displayed in Table 2, and elucidated further in the section that follows.

Main categories	Themes within categories	Sub-themes
Lightness and depth	Depth: Emotions	Elevating and shifting mood Expressing emotions Feeling and identifying emotions
	Depth: Reflective	
	Lightness: Fun and joy	
	Lightness: Freedom	
	Mindful	
Interpersonal connections	With group members	A unique connection through music
	With therapist	Genuine care & openness Therapist as example
Relationship to music	Music in day-to-day life	
	No musical ability required	
Trying something new	Out of my shell and comfort zone	
	Pride and accomplishment	
Generalities and practicalities	Scheduling	More music therapy
	Physical space and resources	

Table 2: Emerging themes from qualitative coding

Main category: Lightness and depth

“Lightness and Depth” captures patients’ most common, and at times paradoxical, descriptions of the music therapy process. Patients portrayed music therapy as facilitating experiences of emotional and self-reflective depth while also affording lightness: fun, distraction, and freedom. One patient described music therapy as “light and heavy at the same time.” Importantly, four patients also noted music therapy’s connection to mindfulness, with one patient describing it as “mindfulness in action.” I note this here, given mindfulness’ promotion of a non-judgemental stance regardless of whatever arises.

Depth: Emotions

When all sub-themes pertaining to emotions are considered together, descriptions of the emotional aspects of music therapy were the most commonly occurring theme, with 99 separate instances coded. Music and music therapy were described as avenues for elevating and shifting mood, as well as for expressing, and identifying and feeling emotions.

Elevating and shifting mood

Many patients observed that the group facilitated positive changes in mood, with several patients noting that they learned to use music for this purpose outside of therapy as well. One patient stated, "I always walked out feeling better than I did coming in;" another noted that "playing in a group reduced anxiety." Some patients linked the shift in mood to specific musical experiences. Referring to instrumental improvisations, one patient noted, "I like how music can be used to create a mood and bring you out of a mood." Commenting on playlist creation, one patient stated, "I love the playlist – moving from an undesired to a desired emotion."

Expressing emotions

Music's ability to provide a medium for the expression of emotions was commonly noted; the presence of this theme within the narrative data aligns with the quantitative findings. Several patients observed that music's expressive qualities were helpful when finding words was challenging. For example, a patient reflected, "Expressing emotions through music is powerful if they are blocked through other channels." One patient noted that they "learned how to express emotion through not only songs but through instruments" and another patient described music as a "different release" that "covers all emotions."

Feeling and identifying emotions

Offering a different perspective than the sub-theme regarding mood elevation, some patients described music therapy as a place in which they could stay with challenging emotions. For example, one patient noted, "I learned to express negative emotions in a healthy way through playing music. This helped me 'lean into' negative emotions instead of avoiding them." Another patient stated, "It helped me to sit through yucky feelings when I was not in my comfort zone and...to notice the peak and then see it decrease." Crucial to these experiences of *feeling*, were patients' observations that they could tolerate challenging emotional experiences. Patients also shared that improvisation and music listening had been vehicles for identifying emotions. For example, one patient noted, "I am not very good at identifying emotions and this helped," and another shared, "[Music therapy] gave me a way to express emotions and brought out certain emotions I didn't know I had."

In connection to this theme, several patients noted that music therapy was emotionally demanding. For example, one patient noted, "It was emotionally demanding to...share musical experiences, especially sharing our personal music; very inspiring, loved it." Not everyone loved this characteristic of the group; two patients described finding the emotional content of the group to be too overwhelming. One individual shared, "The timing of [music therapy] seems to align with when many are 'getting into stuff' in [other groups], so we are exhausted and sometimes triggered the rest of the day."

Depth: Reflective

Several patients described the group as providing space for self-reflection. One patient noted that the group had been important in their process of mourning the death of a family member and “helped [them] dig deep inside.” Another patient described the way in which “listening to and discussing music calms me down and makes me reflective.” One individual wrote, “This programme took me to a place inside myself that was much deeper and more significant to my healing than any other group.” Similarly, several other patients also reflected upon music therapy’s crucial role in their overall mental health recovery.

Lightness: Fun and joy

“Fun”, described by 17 patients, was the most common theme portraying “lightness.” Just as patients appreciated music’s ability to facilitate experiences of emotional depth, patients also described the group as “enjoyable,” a place to “be silly and have fun,” and “joyful.” Importantly, emotional depth and fun were not mutually exclusive experiences; several patients commented on both aspects of the group simultaneously. For example, one patient noted, “It was fun to express feelings through music.” Another patient appreciated “the combination of play with an intent to observe emotions” and still another described music therapy as “a practical, fun, hands-on approach to help with the healing process.”

Lightness: Freedom

Music’s ability to afford freeing experiences was described in a variety of ways. Some patients described feeling freedom while playing instruments, with one patient sharing, “I was able to open up and enjoy freedom to play without judgement by others or self.” Other patients similarly referred to a lack of inhibition, and one individual described experiencing “flow.” Several patients described the group as providing freedom from “heavy” topics; one patient noted, “I got to escape from my thoughts for a little while.” Music’s ability to hold challenging topics and feelings, while also providing a break from them, allowed patients to experience the group differently, depending upon their own needs.

Main category: Interpersonal connections

Patients discussed their experiences of interpersonal connection within group music therapy, both with their fellow group members, and also with the group facilitators.

Connection with group members

In concurrence with quantitative findings, there were 32 comments surrounding patients’ experiences of connections with group members facilitated through music therapy. Some of these comments did not refer to music specifically but rather to the group setting more broadly; for example, several patients described “bonding” and “connectedness” with co-patients, and one individual noted, “Group therapy is excellent to open and share feelings.” However, the majority of comments within this theme noted the unique nature of the connectedness experienced through music. Though patients were in a group-based treatment program—and thus knew the others in their cohort well—many participants noted that music afforded different and at times deeper connections, the opportunity “to bond with cohort in a different way.” Music was described as “cooperative,” “uniting,” and “a vehicle for coming

together." One patient stated, "I feel this is one of my most helpful classes to help me open up" and another "found it helpful using music to break the ice about stories that have affected my life." Music's relational affordances are also relevant to the next sub-theme.

Connection with therapist(s)

An aspect of the group not included in the Likert scale measures, patients made 42 positive comments regarding qualities in me and my facilitation style—and when co-led, the interns also—that they felt contributed to the group's benefits.

Genuine care and openness

The most common sub-theme was that patients felt genuine care from me and the interns, including an open and non-judgemental stance. Stemming from this care, patients described a "friendly," "welcoming," "easy going," "safe," and "accepting" atmosphere in which "everyone feels like their contributions are worthy." One patient stated that the facilitators were "genuine and invested in [patients'] well-being." I was described as "putting everyone at ease" and able to "make [patients] feel comfortable in a calm way." Several patients reflected that they felt listened to; for example, one patient wrote, "I felt heard and that my opinions and ideas mattered." Unlike the other themes and sub-themes, in which patients noted that music assisted in facilitating the group's benefits, here, patients recognised that music alone *does not* necessarily lead to a caring atmosphere. This experience of care required an intentional effort and presence from the facilitators. I will further discuss this theme in the Discussion section.

Therapist as example

Though I grouped together several interrelated therapist qualities in the previous sub-theme, this sub-theme stood out as distinct. Three patients described the music therapists as "examples," particularly surrounding our relationships to music. For example, one individual wrote, "I feel the facilitators are passionate with music and that passion is passed on to the patients." Another stated, "The sheer passion of the [music therapists] was really what sold it. They expressed themselves and that set the stage for patients to feel safe and share." I cannot know exactly what these patients had observed when they described me as having "passion," but certainly the interns and I strove to embody genuine engagement in music-making and a commitment to each group's creative process. It appeared evident that for these patients, role-modelling a relationship to the music was crucial to the group's success as well as to their comfort in engaging.

Main category: Relationship to music

There were 23 comments surrounding the ways in which music therapy impacted patients' relationship to music, whether it affirmed or rekindled an existing relationship or inspired a new one. One patient noted that the group "reminded me of how much I love music," and another stated that it led them to get "back in touch with music." Regarding instrumental playing, one individual wrote, "The programme helped me realize that I am a passionate person about music and piano;" regarding listening, one individual expressed gratitude to have "reconnected with meaningful songs." Poignantly, one patient wrote, "This programme brought a piece of me back. I realized I was missing music."

In contrast, another patient noted that they felt “no connection to music.” This is an important reminder that we cannot assume that all patients will experience a relationship to music, whether through music therapy or in their everyday lives.

Music in day-to-day life

There were 18 comments regarding the ways in which patients intended to incorporate music into their day-to-day lives, a theme that was also validated through the quantitative data. Some of these statements pertained to music listening; for example, one patient wrote, “I will definitely keep working on my playlists,” and another wrote, “I will use playlists in my recovery.” Regarding active involvement in playing and singing, one patient wrote, “It convinced me to sign up for ukulele lessons when I get home” and someone else wrote, “I will look for something musical to do after discharge.” Some patients reflected on the ways they will incorporate the nonmusical benefits of musical involvement into their lives. One individual appreciated “learning how to connect feelings to music and incorporate that into day-to-day activity,” and another patient learned to “use [music] to ground [them]self.”

Three patients stated that they would have liked to receive more tangible resources, for example, “worksheets to keep” or list of musical resources within their hometowns. The latter was something I did on request; given that patients attend this facility from all over the country, it was challenging to have a generic resource list available. Four patients recommended that access to music be provided outside of therapy, for example, through “jam sessions” or instrumental lessons. These suggestions will be explored further in the Discussion section.

No skill required

Regarding patients’ relationships to music, three individuals appreciated that there was no musical skill required to participate in music therapy. I have included this sub-theme within the “Relationship to Music” theme, given the potential implications of the realisation that one can meaningfully participate in music without being an expert. One patient wrote, “[Music therapy] is structured in a way so that no one needs any actual musical ability,” and another patient wrote, “Even though I don’t play any instruments I found it easy to just play and totally unexpected.” Music-making was perceived to be accessible for beginners; such observations could impact the way in which these individuals perceive the possibility of musical involvement in the future.

Main category: Trying something new

Many participants reflected on the opportunity to try something new through music therapy. Eight individuals commented on trying new instruments. Other comments pertained to the experiences of group music-making, playlist creation, or music therapy as a whole; as one participant noted, “I learned there are alternative ways of dealing with mental illness.” Several patients noted that they had initially been nervous or uncomfortable, due to music therapy being unfamiliar, but that these feelings subsided as the group progressed. One individual shared that they had “gained confidence by doing something new” and another reflected that undertaking a new activity helped them to “get over their self-consciousness.” Two patients shared suggestions for easing the group into the new experience more slowly; one patient suggested spending more time drumming prior to introducing instruments, and another requested more time to develop familiarity with the instruments.

Out of my shell

The fact that music therapy was new, and also *creative*, prompted a number of patients to identify that the group involved “taking a risk;” leaving one’s “comfort zone” or coming out of one’s “shell” were common descriptors. One participant wrote that the most beneficial part of the group had been “getting out of my comfort zone – until this group I have only ever sung in my car or shower where no one could hear me.” Another individual shared: “Music is a shy part of my life. I found attending music therapy helped me and would say that it was my favourite therapy.” Several patients linked coming out of their shells to increased confidence.

Pride and accomplishment

Four patients noted that trying something new had sparked feelings of pride. One patient wrote, “I was amazed at what we were able to put together in such a short time.” Another patient felt a sense of accomplishment regarding their completed playlist, and wrote, “[Music therapy] gave me the opportunity to reconnect with music – I had lost this during my depression. The [playlist] assignment was fantastic and I’m proud in me accomplishing this.”

Main category: Generalities and practicalities

There were 25 general positive statements about music therapy (for example, “loved it” or “wonderful program”) that were generic and thus coded separately from the main themes noted above. Two individuals noted that the programme was “not helpful” but did not expand. Patients also made comments about practical matters, such as space, resources, and scheduling.

Physical space and resources

Three patients made suggestions regarding the physical space. One involved the lack of air-conditioning, which has been remedied; the other two involved patients’ sensitivities to loud noise, including concerns about the volume within the music room, and also about noise coming from a neighbouring space. These are known and valid acoustical challenges at the facility. Five patients noted that they wished that there had been a greater variety of instruments available.

Scheduling

For the two weeks that patients attend music therapy, they do not attend other programming offered at the same time. Four patients suggested that this overlap be remedied, so as to be able to attend both programmes. Two patients suggested that music therapy be optional.

The overwhelming scheduling feedback, based in 50 comments, was that patients wanted more music therapy, whether for longer sessions or for a greater number of weeks. Some patients connected these requests to their perceptions surrounding music therapy’s value in treatment. One individual wrote, “I would offer it earlier and more often as it always uplifted me.” Another patient reflected that they prefer music to talk therapy, and stated, “It would be great if patients like myself could have more opportunities to explore [music therapy].”

Alongside patients’ quantitative feedback—that the group was at least “quite a bit” helpful in the measured domains for most patients—qualitative feedback elucidated patients’ experiences, including

those of lightness and depth, interpersonal connections, relationships to music, and trying something new. I will move now into a discussion surrounding these results.

DISCUSSION

Overall, this programme evaluation appeared to validate the success of music therapy from the perspective of patients. Quantitative results in four of the five domains had mean scores over 4 (i.e., more than “quite a bit”) and also relatively small standard deviations, meaning that most patients experienced mood elevation and group connection in music therapy, and believed they had greater tools for self-expression and coping through music. With regards to the mean score for anxiety reduction being slightly slower, at 3.9, I will propose that, for some people, music therapy itself was anxiety-provoking. As noted by a number of participants, creative music-making in a group context involved a substantial amount of personal risk-taking. Leaving one’s “comfort zone” may have been clinically indicated and ultimately beneficial for many patients, but anxiety may have remained. The score of 3.9 does still indicate that a majority of patients experienced anxiety reduction through music therapy. I interpret these mean and median scores as promising findings, particularly recognising that many participants had tried various therapeutic modalities previously and were experiencing hopelessness about their mental health.

The main themes that emerged from the qualitative analysis speak to affordances of musical experience, as well as characteristics of my facilitation style and philosophy of practice, which inevitably impacted patients’ experiences. For example, the predominance of comments surrounding music’s emotive impact resonates with music’s ability to connect us to our emotions (Spitzer, 2020). These comments likely also reflect my orientation as a music psychotherapist, as I often focused upon music’s emotive potential within group improvisations and discussions.

In complementarity to themes of “depth,” group members’ reflections on “lightness” also affirm affordances of music, while reflecting my resource-oriented and music-centred orientation. Resource-oriented music therapy draws upon elements of positive psychology, including the recognition that “treatment is not just fixing what is broken; it is nurturing what is best” (Seligman & Csikszentmihalyi, 2000, p. 7). Music therapists can become uncomfortable when our work is described as “fun,” concerned that our profession will not be taken seriously. Yet, playfulness is a human need, one that individuals facing institutionalisation have minimal opportunity to have met. Music’s affordances in this area—the fun, and the realisation that “I am capable of having fun”—are invaluable to recovery, particularly if we view the process as one not only of symptom reduction, but of discovering what makes life living (Anthony, 1993).

Patients’ feedback surrounding my own and the interns’ roles as facilitators provides a reminder of the therapeutic relationship’s contribution to therapy’s effectiveness. Research surrounding the “common factors” among approaches to psychotherapy supports the notion that therapeutic rapport—as evidenced by characteristics such as warmth, empathy, trust—is a more powerful predictor of therapy’s success than the therapist’s specific approach (Wampold & Imel, 2015). Silverman (2019) suggests that identifying factors that contribute to strong therapeutic alliances in music therapy is urgent, given that mental health care is becoming increasingly brief. We have the opportunity to create supportive, effective, and ethical therapeutic relationships through music,

but music does not guarantee that such qualities will be fostered. We have a responsibility to be intentional as we build rapport with patients.

Trustworthiness, limitations, and directions for future research

This programme evaluation undoubtedly has limitations. I acknowledge that my biases about music therapy's role in mental health impacted my creation of the questionnaire. Given that this inpatient programme is intended to treat depression and anxiety, the inclusion of mood elevation and anxiety reduction in the evaluation are straightforward. However, the inclusion of emotional expression, musical resource development, and group connection, reflect my values surrounding the affordances of musical engagement. A different therapist may have measured different domains, and thus achieved different results. I also recognise that, despite my genuine commitment to representing the data with integrity, in holding a dual role as therapist and programme evaluator I undoubtedly had a vested interest in receiving positive feedback about the program. Trustworthiness was increased through the presence of a Research Assistant; this individual assisted with data analysis and had no connection to music therapy or to the patients.

I recognise in hindsight that the five quantitative questions could be viewed as leading patients towards a positive response, which was certainly not my intention. In addition, the questionnaire was designed so that patients could complete it within a few minutes; thus, most patients' responses to qualitative questions were brief. Narrative feedback was largely extremely positive; however, many responses were very short, such as "great" or "loved it." Two patients wrote briefly that they had not found music therapy to be helpful. Due to the questionnaire's design, there was no opportunity to invite individuals to expand on their responses, whether positive or critical. In building upon these results in future research, the inclusion of interviews within the study design, and/or providing a more detailed survey, would increase the possibility of gaining richer descriptions.

In addition to gathering richer narratives, in future research it would be beneficial to follow-up with patients several weeks or months after discharge from the facility. The benefits of music therapy may be perceived as lesser after the emotional high of creating music with others has subsided. The opposite could also be true, that as people reflect back on their time at the facility, they feel more strongly about the value of music therapy in their treatment. It would also be beneficial to collect patients' self-reported mood and anxiety scores before and after each session, in order to collect quantitative, comparative data surrounding these key variables.

Balancing music-centredness with music psychotherapy

Given psychotherapy's focus upon nonmusical domains, there can exist points of tension between the tenets of music-centred music therapy versus those of music psychotherapy (Aigen, 2014). I view this as a healthy and dynamic tension rather than seeing these approaches as mutually exclusive. Despite the context of this group—an inpatient mental health facility—it became apparent to me early on that it would not be an appropriate setting in which to exclusively draw upon a psychotherapeutic orientation to practice. My facilitation deliberately embraced theoretical and practical points of

complementarity and tension between music-centred and psychotherapeutic approaches. I will consider two observations in this regard.

The music therapy programme was, at its outset, added to patients' already busy therapy schedules. Therapy, particularly psychotherapy, is intensive and often exhausting; *more* therapy is not always better. I learned to recognise when participants arrived emotionally saturated. I learned to overtly tell patients that I trusted them to take the group at their own pace: that they may wish to focus on the musical sounds, or they may wish to consider music's connection to their emotions. When a cohort informed me that they had already engaged in intense group therapy that day, I would intentionally bring a purely music-centred lens to the group, engaging in music-making with the goal to engage creatively, re-connect with one another, or have fun.

In addition to validating patients' need for a break from therapy, other patients did not wish to use music for the purpose of therapy. Solli and Rolvsjord (2015)'s research with adults with psychosis note that patients often attended music therapy as "a break from treatment" (p. 74). These authors recognise a paradox—that music therapy can be helpful in treatment because patients view it as "the opposite of treatment," distinct from other appointments. Their findings resonate with my conviction that musical engagement is a human need. As a therapist and educator, I find myself to constantly be balancing advocacy for music therapy's role in healthcare with advocacy for people's access to *music*, not only to reach clinical goals, but also to foster normalcy, positivity, connection, and creativity. Four patients formally requested, through this programme evaluation, to have access to music-making opportunities outside of music therapy. Anecdotally, while working at this facility I had many hallway conversations with patients looking for similarly informal musical involvement. I am increasingly committed to enhancing people's access to normative experiences of music, both within and outside therapy.

CONCLUSION

This programme evaluation documents patients' perceptions of the role of group music therapy within treatment for depression and anxiety. Through mixed-methods analysis, the data tells a story of music therapy's impact surrounding mood, connection with emotions, connection with others, and connection with music. Patients' perspectives celebrate the notion that short-term, group music therapy can both invite and explore in-depth psychotherapeutic process while also developing and celebrating patients' resourceful use of music in their everyday lives.

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APPENDIX 1

PROGRAMME FEEDBACK Music Therapy Group

1 = Not at all 2 = A little bit 3 = Somewhat 4 = Quite a bit 5 = A lot

This group helped to elevate my mood. 1 2 3 4 5

This group helped to reduce my anxiety. 1 2 3 4 5

This group helped me to connect with my co-patients. 1 2 3 4 5

I learned ways I can use music to cope in my life. 1 2 3 4 5

I found ways to express myself through music 1 2 3 4 5

What did you find useful/helpful about the program?

What recommendations would you make for the programme going forward? Is there anything you wish to see changed based on your experiences?

Thank you for taking the time to fill out this evaluation 😊

Μουσικοκεντρική ψυχοθεραπεία για ενήλικες με διαταραχές διάθεσης και άγχους: Μια αξιολόγηση προγράμματος

Elizabeth Mitchell

ΠΕΡΙΛΗΨΗ

Αυτό το άρθρο παρουσιάζει τη δημιουργία και την αξιολόγηση ενός προγράμματος ομαδικής μουσικοθεραπείας για ενήλικες, εντός ενός ενδονοσοκομειακού προγράμματος θεραπείας για διαταραχές διάθεσης και άγχους στο Νοτιοδυτικό Οντάριο του Καναδά. Η συγγραφέας συζητά αρχικά τη διαδικασία που ακολουθήθηκε για την ανάπτυξη του προγράμματος και το συντονισμό μιας σειράς τεσσάρων κλειστού τύπου ομαδικών συνεδριών σε πλαίσιο μουσικοκεντρικής ψυχοθεραπείας που είναι προσανατολισμένη στους πόρους. Στη συνέχεια, η συγγραφέας παρουσιάζει τα αποτελέσματα από την αξιολόγηση του προγράμματος το οποίο περιλάμβανε 154 ασθενείς, αναδεικνύοντας τις βιωμένες εμπειρίες από την ομάδα μουσικοθεραπείας. Τα ποσοτικά αποτελέσματα καταγράφουν τις αντιλήψεις των ασθενών για την επίδραση της μουσικοθεραπείας σε τομείς όπως η διάθεση, το άγχος, οι διαπροσωπικές σχέσεις, η έκφραση και η ανάπτυξη μουσικών πόρων. Τα ποιοτικά αποτελέσματα διερευνούν τις εμπειρίες των ασθενών στη μουσικοθεραπεία, εστιάζοντας σε τομείς όπως η ελαφρότητα και το βάθος, οι διαπροσωπικές συνδέσεις, οι σχέσεις με τη μουσική και η διάθεση για δοκιμή κάτι νέου. Οι εμπειρίες και οι αντιλήψεις των ασθενών για την επίδραση της ομάδας επιβεβαιώνουν ότι η μουσικοθεραπεία μπορεί να ενεργοποιήσει μια βαθιά θεραπευτική διαδικασία, ενώ ταυτόχρονα προάγει και γιορτάζει τη δημιουργική χρήση της μουσικής στην καθημερινή ζωή των ασθενών.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

μουσική ψυχοθεραπεία, αξιολόγηση προγράμματος, κατάθλιψη, άγχος, μουσικοκεντρική, προσανατολισμένη στους πόρους

ΑΡΘΡΟ

Κοινοτικά προγράμματα και παρεμβάσεις μουσικής ή/και χορού για ανήλικους πρόσφυγες: Μια βιβλιογραφική ανασκόπηση

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ΠΕΡΙΛΗΨΗ

Η αναγνώριση του ρόλου των τεχνών στην προσπάθεια ενίσχυσης της κοινωνικής ευημερίας έχει οδηγήσει στην ανάπτυξη πρακτικών, οι οποίες απευθύνονται κυρίως σε ευπαθείς κοινωνικά ομάδες. Σήμερα, οι κοινοτικές τέχνες αποτελούν ένα διακριτό πεδίο καλλιτεχνικής πράξης και επιστημονικής έρευνας, το οποίο έχει ως στόχο τη διαχείριση κοινωνικών προβλημάτων και την ενίσχυση της κοινωνικής συνοχής. Το προσφυγικό ζήτημα είναι διαχρονικό και ιδιαίτερα επίκαιρο τα τελευταία χρόνια. Τα παιδιά πρόσφυγες στην πορεία του επιπολιτισμού τους αντιμετωπίζουν πολλές δυσκολίες, όπως πρόσβαση σε δημόσια αγαθά και υπηρεσίες, αποσταθεροποίηση, συναισθηματικές προκλήσεις, ζητήματα ταυτότητας, κοινωνικές διακρίσεις και περιθωριοποίηση. Σκοπός της παρούσας έρευνας είναι η μελέτη πρακτικών μουσικής και χορού, οι οποίες αξιοποιούνται σε προγράμματα για ανήλικους πρόσφυγες, ως προς το περιεχόμενο και την αποτελεσματικότητά τους. Για την επίτευξη του σκοπού διεξήχθη περιγραφική ανασκόπηση ερευνών με αντικείμενο κοινοτικά προγράμματα μουσικής ή/και χορού που απευθύνονται σε αυτό τον πληθυσμό. Σύμφωνα με τα αποτελέσματα, η ποικιλία του περιεχομένου είναι μεγάλη με εστίαση στη μουσική, ενώ ο χορός φαίνεται να χρησιμοποιείται κυρίως ως συμπληρωματική δραστηριότητα στα κοινοτικά μουσικά προγράμματα. Είναι σημαντικό ότι, ανεξάρτητα από το περιεχόμενο των προγραμμάτων, η μουσική και ο χορός αναδεικνύονται ως πολύτιμα εργαλεία για την προσωπική ανάπτυξη και την επικοινωνία και ταυτόχρονα μπορούν να συμβάλουν στην κοινωνική συνοχή και την ενίσχυση του διαπολιτισμικού διαλόγου.

ΒΙΟΓΡΑΦΙΕΣ ΣΥΓΓΡΑΦΕΩΝ

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ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

κοινοτική μουσική,
κοινοτικός χορός,
κοινοτικά
προγράμματα,
κοινοτικές
παρεμβάσεις, ανήλικοι
πρόσφυγες

Ιστορία δημοσίευσης:
Υποβολή 11 Αυγ. 2024
Αποδοχή 10 Μαρ. 2025
Δημοσίευση 16 Μαΐου 2025

Μουσική του Πανεπιστημίου Μακεδονίας. Απόφοιτη του Μουσικού Σχολείου Θεσσαλονίκης, με ελεύθερη σπουδή στο χορό, το αυτοσχεδιαστικό θέατρο και πέντε κύκλους ετήσιων μουσικοπαιδαγωγικών σεμιναρίων του Κρουσόφωνου (2010-2015). Έχει εργαστεί σε νηπιαγωγεία (2015-2024), δανειζόμενη στοιχεία από την κριτική παιδαγωγική και τη μουσικοπαιδαγωγική προσέγγιση Orff. Συνεργάτης του Κρουσόφωνου ως εκπαιδευτικός σε εργαστήρια μουσικής για παιδιά και εμψυχώτρια σε μουσικοθεατρικές παραστάσεις (2015-2020) και της Yurrie Camp ως εκπαιδευτικός σε εργαστήρια χορού για παιδιά (2005-2010). [nays-th@hotmail.com] Η **Ολυμπία Αγαλιανού** είναι κάτοχος Διδακτορικού Διπλώματος του Τμήματος Φιλοσοφίας – Παιδαγωγικής και Ψυχολογίας (Ε.Κ.Π.Α), πτυχιούχος του Τμήματος Επιστήμης Φυσικής Αγωγής και Αθλητισμού Αθηνών (Ε.Κ.Π.Α), απόφοιτος διετούς μεταπτυχιακής επιμόρφωσης στη μουσικοκινητική αγωγή Orff (Σχολή Μωραΐτη), τριετής εκπαίδευση στη χοροθεραπεία, τετραετής εκπαίδευση στη συστημική συμβουλευτική, σπουδή στο χορό, τη μουσική και το θέατρο. Υπηρέτησε στην πρωτοβάθμια εκπαίδευση (1998-2017). Συνεργάτης του Ευρωπαϊκού Πανεπιστημίου Κύπρου (2014-2016) και της Σχολής Μωραΐτη (2007-2016). Υπηρετεί ως μέλος Ειδικού Ερευνητικού Προσωπικού στο Τμήμα Εκπαίδευσης και Αγωγής στην Προσχολική Ηλικία της Σχολής Επιστημών Αγωγής του Ε.Κ.Π.Α. και διδάσκει σε μεταπτυχιακά προγράμματα του Ε.Κ.Π.Α, του Πανεπιστημίου Μακεδονίας και του Δημοκρίτειου Πανεπιστημίου. [oagalianou@ecd.uoa.gr] Η **Λελούδα (Λήδα) Στάμου** είναι καθηγήτρια μουσικής παιδαγωγικής στο Τμήμα Μουσικής Επιστήμης και Τέχνης του Πανεπιστημίου Μακεδονίας, ιδρύτρια και διευθύντρια του Προγράμματος Μεταπτυχιακών Σπουδών «Μουσική και Κοινωνία», καθώς και επιστημονικά υπεύθυνη του Baby Artist. Έχει πιστοποιηθεί στη διδασκαλία με τη μέθοδο Suzuki, τη μέθοδο Orff, και τη Θεωρία Μουσικής Μάθησης. Έχει διδάξει στο University of Nevada, Las Vegas των Η.Π.Α. Είναι επιστημονικά υπεύθυνη του έργου «Μουσική και πολιτισμός στην υπηρεσία της υγείας, της ευζωίας και της κοινωνικής ενσωμάτωσης». Έχει δημοσιεύσει σημαντικό αριθμό άρθρων και κεφαλαίων σε βιβλία. Επί σειρά ετών διετέλεσε πρόεδρος της Ελληνικής Ένωσης για τη Μουσική Εκπαίδευση. [Istamou@uom.edu.gr]

ΕΙΣΑΓΩΓΗ

Η μετακίνηση των πληθυσμών είναι ένα φαινόμενο που παρατηρείται σε όλες τις ιστορικές περιόδους και γεωγραφικές περιοχές. Οι λόγοι που οδηγούν τους ανθρώπους στη μετεγκατάσταση είναι πολλοί και συχνά ο εκτοπισμός είναι αναγκαστικός. Η παρεμπόδιση της ελεύθερης μετακίνησης των ανθρώπων ανά τον κόσμο προκαλεί μια πληθώρα δυσκολιών για τον προσφυγικό πληθυσμό, ο οποίος αντιμετωπίζει μία διπλή πρόκληση: ενώ αναγκάζεται να τραπεί σε φυγή από τη χώρα καταγωγής για λόγους προστασίας, συχνά δεν απολαμβάνει επαρκή προστασία ούτε στη χώρα υποδοχής. Το 2022, ως αποτέλεσμα του πολέμου στην Ουκρανία και άλλων συρράξεων, ο αριθμός των αναγκαστικά εκτοπισμένων ανθρώπων (forcibly displaced people) ξεπέρασε για πρώτη φορά τα 100 εκατομμύρια, σημειώνοντας τη μεγαλύτερη αύξηση από χρόνο σε χρόνο έως σήμερα (UNHCR, 2022). Μετά τις ένοπλες συγκρούσεις στο Σουδάν τον Απρίλιο 2023, ο αριθμός αυτός αυξήθηκε στα 110 εκατομμύρια φανερώνοντας το μέγεθος του προβλήματος (UNHCR, 2023). Ο τόπος καταγωγής των προσφύγων ποικίλει ενώ η πλειοψηφία τους προέρχεται από τη Συρία, το Αφγανιστάν, τη Βενεζουέλα, το Νότιο Σουδάν, τη Μιανμάρ, τη Λαϊκή Δημοκρατία του Κογκό, τη Σομαλία, από χώρες της κεντρικής Αφρικής και την Ουκρανία (UNHCR, 2023). Τα παιδιά, παρότι αποτελούν μόλις το 1/3 του παγκόσμιου πληθυσμού, το 2022 αντιπροσώπευαν τουλάχιστον το 41% του προσφυγικού πληθυσμού (UNICEF, 2023). Αυτό σημαίνει πως εκατομμύρια παιδιά πρόσφυγες, πολλά εκ των οποίων ασυνόδευτα, βρίσκονται εκτεθειμένα σε επισφαλή περιβάλλοντα και αντιμετωπίζουν μορφές βίας, δυσμενείς συνθήκες διαβίωσης, συναισθηματικές δυσκολίες, αποσχολοποίηση ή δυσκολίες προσαρμογής σε σχολικά και κοινωνικά πλαίσια. Είναι φανερό πως η προσφυγική πραγματικότητα συνεχίζει να διαμορφώνει ειδικές οικονομικές και κοινωνικές συνθήκες, καθιστώντας ολοένα εντονότερη την ανάγκη να ληφθούν μέτρα για τη συμπερίληψη και την κοινωνική συνοχή των περιθωριοποιημένων αυτών πληθυσμών.

Μελέτες δείχνουν ότι οι τέχνες της μουσικής και του χορού μπορούν να συμβάλλουν στην ανθρώπινη αλληλεπίδραση και ευημερία (Στάμου και συν., 2018). Η μουσική και ο χορός αποτελούν μέσα έκφρασης και επικοινωνίας σε όλη την πορεία της ανθρώπινης ύπαρξης. Παράλληλα, ως κοινωνικές τέχνες, μπορούν να λειτουργήσουν ευεργετικά για την προσωπική ανάπτυξη, την ειρηνική συνύπαρξη και ανταλλαγή μεταξύ ανθρώπων που φέρουν διαφορετικό πολιτισμικό

κεφάλαιο, καθώς και την κοινωνική συνοχή (Agalianou, 2021). Η αναγνώριση της σημασίας των τεχνών για την κοινωνική ευημερία οδήγησε στην ανάπτυξη πρακτικών κοινοτικών τεχνών/community arts (Στάμου και συν., 2018), οι οποίες απευθύνονται κυρίως σε ευπαθείς κοινωνικά ομάδες, όπως για παράδειγμα οι πρόσφυγες. Σήμερα, οι κοινοτικές τέχνες αποτελούν ένα διακριτό πεδίο καλλιτεχνικής πράξης και επιστημονικής έρευνας, το οποίο έχει ως κύριο στόχο την επίλυση κοινωνικών προβλημάτων και την προαγωγή της ευημερίας και της κοινωνικής συνοχής (Higgins, 2012· Veblen, 2008· Webster, 1999). Στους ειδικούς στόχους συμπεριλαμβάνονται η ενίσχυση της «φωνής» των συμμετεχόντων, η απαλοιφή του κοινωνικού στιγματισμού και η επαναδιαπραγμάτευση της ατομικής και συλλογικής τους ταυτότητας (Community Music Activity Commission, n.d.· Webster, 1999).

Σε αυτό το πλαίσιο, η μελέτη των κοινοτικών προγραμμάτων με μουσικό και χορευτικό περιεχόμενο παρουσιάζει ιδιαίτερο ενδιαφέρον. Για το λόγο αυτό, αποφασίσαμε την διεξαγωγή περιγραφικής ανασκόπησης ερευνών που μελετούν κοινοτικά προγράμματα μουσικής και χορού, τα οποία απευθύνονται σε ανήλικους πρόσφυγες. Συγκεκριμένα, διατυπώθηκαν τα εξής ερωτήματα: α) Ποια είναι τα δομικά και ποιοτικά στοιχεία των κοινοτικών προγραμμάτων μουσικής ή/και χορού τα οποία απευθύνονται σε ανήλικους πρόσφυγες; β) Ποια είναι η επίδραση των προγραμμάτων αυτών στους ανήλικους πρόσφυγες;

Οι συγγραφείς του άρθρου δραστηριοποιούνται στο χώρο της εκπαίδευσης, της κοινοτικής μουσικής και του χορού, καθεμία στο ιδιαίτερο εργασιακό της πλαίσιο. Η παρούσα έρευνα αποτελεί μέρος μιας σειράς ερευνών που εστιάζουν στο σχεδιασμό παρεμβάσεων κοινοτικής μουσικής για ομάδες που βιώνουν κοινωνικό αποκλεισμό και σχεδιάζονται στο πλαίσιο του Μεταπτυχιακού Προγράμματος Μουσική και Κοινωνία (κατεύθυνση Μουσική Εκπαίδευση και Κοινοτική Μουσική) του Πανεπιστημίου Μακεδονίας. Η συγκεκριμένη έρευνα συνοψίζει ένα από τα πρώτα ολοκληρωμένα στάδια μιας ευρύτερης ερευνητικής προσπάθειας, η οποία έχει προχωρήσει και συνεχίζει με στόχο τον κατά το δυνατόν και κατά περίπτωση, βέλτιστο σχεδιασμό παρεμβάσεων που απευθύνονται σε ανήλικους πρόσφυγες. Η συλλογή των άρθρων και η πρώτη ανάλυση έγινε από την πρώτη συγγραφέα. Στη συνέχεια, οι δύο συν-συγγραφείς, ξεχωριστά και έπειτα σε συνεργασία, πρόσθεσαν τη δική τους κριτική και αναστοχαστική αντιμετώπιση της ανάλυσης. Το τελικό κείμενο προήλθε από τη στενή συνεργασία και των τριών συγγραφέων και αποτελείται από δύο κύρια μέρη. Στο πρώτο επιχειρείται ο προσδιορισμός των εννοιών που αφορούν την έρευνα, ενώ στο δεύτερο παρουσιάζεται η ανασκόπηση επιλεγμένων ερευνών με σκοπό να απαντηθούν τα ερευνητικά ερωτήματα της παρούσας μελέτης.

ΕΝΝΟΙΟΛΟΓΙΚΟΙ ΠΡΟΣΔΙΟΡΙΣΜΟΙ

Σύμφωνα με τη Σύμβαση της Γενεύης (1951), πρόσφυγας θεωρείται το πρόσωπο το οποίο αναγκάζεται να εγκαταλείψει τη χώρα καταγωγής του εξαιτίας καταστάσεων εκτεταμένης βίας, πολεμικών συγκρούσεων και διώξεων. Για το λόγο αυτό, υπάρχει δικαιολογημένος φόβος διώξης λόγω φυλής, θρησκείας, εθνικότητας, συμμετοχής σε συγκεκριμένες κοινωνικές ομάδες ή πολιτικών πεποιθήσεων, με αποτέλεσμα ο πρόσφυγας να αδυνατεί ή να μην επιθυμεί την απόκτηση προστασίας από τη χώρα του ή την επιστροφή σε αυτήν (UNHCR, 2019). Οι πρόσφυγες δεν επιθυμούν να εγκαταλείψουν τον τόπο τους, αλλά αδυνατούν να επιστρέψουν σε αυτόν, αντίθετα

με τους μετανάστες, για τους οποίους όσο δύσκολη και αν είναι η μετεγκατάστασή τους, δεν παύει να αποτελεί επιλογή και εκούσια πράξη. Οι μετανάστες δεν έχουν υποστεί διωγμούς, φόβο και απειλή κατά της ζωής τους στις χώρες από τις οποίες προέρχονται. Κατά κύριο λόγο, εγκαταλείπουν τη χώρα τους για εργασιακούς και εκπαιδευτικούς λόγους ή ακόμα για να επανενωθούν με τις οικογένειές τους και διατηρούν πάντοτε τη δυνατότητα επιστροφής σε αυτή, εάν οι ίδιοι το αποφασίσουν (Bernard, 1976).

Οι πρόσφυγες αποτελούν έναν ετερογενή πληθυσμό και παρουσιάζουν σημαντικές διαφορές ως προς το εθνικό, γλωσσικό, πολιτισμικό, μορφωτικό και οικονομικό τους υπόβαθρο (Agalianou, 2018· Agalianou, 2021· ΕΕ ΥΠΠΕΘ, 2017). Επομένως, η διαφορετικότητα ανάμεσα στις προσφυγικές ομάδες και κοινότητες είναι μεγάλη. Στο σύνολό τους, φέρουν συναισθήματα δυσφορίας και αναστάτωσης, τα οποία πηγάζουν από το πλήγμα της απώλειας και του ξεριζωμού, ενώ δεν αποκλείεται να εξελιχθούν σε σοβαρότερες διαταραχές (Papadopoulos, 2007). Επίσης, οι διαδικασίες που ακολουθούν για να φύγουν από τον τόπο τους, οι συνθήκες του ταξιδιού, καθώς και οι συνθήκες στην εκάστοτε χώρα υποδοχής, καθορίζουν σε μεγάλο βαθμό τον τρόπο που βιώνουν τις ψυχολογικές επιπτώσεις. Ωστόσο, ο τρόπος που βιώνεται η προσφυγική πραγματικότητα αποτελεί εξατομικευμένη υπόθεση (Papadopoulos, 2007), καθώς κάθε άνθρωπος διαφέρει ως προς το πώς διαμορφώνει την ταυτότητά του (Kunz, 1981).

Η κοινωνική συνοχή αναφέρεται στην ποιότητα των σχέσεων και των συνδέσεων εντός μιας κοινωνίας, η οποία χαρακτηρίζεται από εμπιστοσύνη, αίσθημα του ανήκειν, αλληλοβοήθεια και συμμετοχή στο κοινό καλό. Αποτελεί μια πολυδιάστατη και δυναμική έννοια που εκδηλώνεται σε διάφορους βαθμούς, ανάλογα με τη διάθεση των ατόμων να συνεργαστούν και να αλληλοϋποστηριχθούν (Schiefer & Van der Noll, 2017). Περιλαμβάνει τόσο τις κάθετες όσο και τις οριζόντιες αλληλεπιδράσεις των ατόμων και των ομάδων και εκφράζεται μέσα από τις στάσεις και τις συμπεριφορές τους (Chan et al., 2006). Τα βασικά χαρακτηριστικά της κοινωνικής συνοχής περιλαμβάνουν την ποιότητα των κοινωνικών σχέσεων (όπως κοινωνικά δίκτυα, αποδοχή της διαφορετικότητας και συμμετοχή στα κοινά), την ταύτιση με το κοινωνικό σύνολο και τον προσανατολισμό προς το κοινό συμφέρον (όπως η αίσθηση ευθύνης, η αλληλεγγύη και η συμμόρφωση με τους κανόνες). Παράλληλα, η κοινωνική συνοχή επηρεάζεται από παράγοντες όπως η ισότητα, η ποιότητα ζωής και οι κοινές αξίες, τα οποία θεωρούνται τόσο προϋποθέσεις όσο και αποτελέσματα αυτής (Schiefer & Van der Noll, 2017).

Κάθε κοινοτική τέχνη έχει τις δικές της μεθόδους (Brooks, 1988), ενώ ως κοινά σημεία εντοπίζονται η έμφαση στη δημιουργική διαδικασία, η ενεργή συμμετοχή, η ατομική ευθύνη απέναντι στη μάθηση, η ανταλλαγή και η συνδιαμόρφωση του περιεχομένου (Higgins, 2012· Veblen, 2008· Webster, 1999). Όσον αφορά την κοινοτική μουσική και τον κοινοτικό χορό, στη διεθνή βιβλιογραφία εντοπίζονται ποικίλοι ορισμοί (Buck & Snook, 2018· Dykema, 1916· Koorman, 2007· Higgins, 2012· Veblen, 2008), καθώς η έννοιά τους διαφοροποιείται ανάλογα με το πλαίσιο πράξης και τις ιδιαιτερότητες των συμμετεχόντων στα κοινοτικά προγράμματα (Veblen, 2008). Εστιάζοντας στην κοινοτική μουσική θα λέγαμε πως πρόκειται για μια προσέγγιση μουσικής πράξης πέραν των ορίων της τυπικής διδασκαλίας και μάθησης, η οποία τείνει να αντανakλά τη μουσική ταυτότητα μιας ομάδας (Higgins, 2012). Εστιάζει πρώτιστα στη συμμετοχή των ανθρώπων, το διαπολιτισμικό διάλογο, την παροχή ίσων ευκαιριών πρόσβασης στην τέχνη και το καλλιτεχνικό αποτέλεσμα προκύπτει από αυτά (Higgins, 2012· Στάμου & Λίτος, 2024). Ως προς τον κοινοτικό χορό,

οι αναφορές και οι πληροφορίες είναι λιγότερες συγκριτικά με άλλες μορφές τέχνης που αξιοποιούνται σε κοινοτικά περιβάλλοντα. Πρόκειται για μια πρακτική, η οποία δεν αφορά σε συγκεκριμένο είδος χορού, αλλά συμμετοχικές πρακτικές, ανεξάρτητα από την ηλικία και το επίπεδο δεξιοτήτων. Στοχεύει στην έκφραση, την αυτογνωσία, την ικανότητα για λήψη αποφάσεων και τη δημιουργία και διαχείριση των διαπροσωπικών σχέσεων μέσω της κίνησης (Amans, 2008· Brinson, 2004). Στον κοινοτικό χορό το σώμα αποτελεί όχημα έκφρασης εσωτερικών διεργασιών και μπορεί να οδηγήσει στην ανάδυση στην επιφάνεια απωθημένων εμπειριών και συναισθημάτων, προσφέροντας έτσι δυνατότητα για συνειδητοποίηση και αντιμετώπιση δύσκολων συναισθηματικών καταστάσεων (Kornblum & Halsten, 2006). Οι κοινοτικοί μουσικοί/χορευτές επιτελούν την τέχνη τους με την ομάδα, εμπυχώνουν, διευκολύνουν και συντονίζουν (Στάμου και συν, 2023). Σε αυτή την έρευνα, αναφερόμαστε σε αυτούς χαρακτηρίζοντάς τους ως διαμεσολαβητές, μια ελεύθερη απόδοση του όρου "facilitator", ο οποίος χρησιμοποιείται από πολλούς ερευνητές και έλκει την καταγωγή του από την προσωποκεντρική θεωρία του Carl Rogers (Agalianou, 2021· Rogers, 1970).

ΑΝΑΖΗΤΗΣΗ ΕΡΕΥΝΩΝ ΚΑΙ ΑΡΧΙΚΕΣ ΠΑΡΑΤΗΡΗΣΕΙΣ

Προκειμένου να διερευνηθούν τα περιεχόμενα, ο τρόπος λειτουργίας και η αποτελεσματικότητα προγραμμάτων κοινοτικής μουσικής και χορού, αναζητήθηκαν δημοσιευμένες έρευνες στην αγγλική και ελληνική γλώσσα, οι οποίες πραγματεύονται σχετικά θέματα. Η βιβλιογραφική αναζήτηση ολοκληρώθηκε τον Δεκέμβριο του 2024, χωρίς περιορισμό στην ημερομηνία δημοσίευσης των ερευνών. Η αναζήτηση έγινε στις ηλεκτρονικές βάσεις δεδομένων Google Scholar, Scopus και ERIC και χρησιμοποιήθηκαν λέξεις-κλειδιά που σχετίζονται με τη μουσική και το χορό (*Music, Dance, Movement, Community Music, Community Dance*), τα εκπαιδευτικά προγράμματα και παρεμβάσεις (*Program, Implementation, Initiative, Intercultural Education*) και τον ανήλικο προσφυγικό πληθυσμό (*Refugee Children, Asylum Seekers, Adolescents*), καθώς και συνδυασμούς αυτών στην αγγλική και την ελληνική γλώσσα. Στην αρχή επιχειρήθηκε ο εντοπισμός ερευνών που αφορούν παιδιά πρόσφυγες ηλικίας έως 12 ετών. Ωστόσο, διαπιστώθηκε σημαντική έλλειψη και για το λόγο αυτό το ηλικιακό εύρος διευρύνθηκε, ώστε να συμπεριλάβει και έφηβους πρόσφυγες, να αφορά δηλαδή σε ανήλικους πρόσφυγες.

Η δήλωση της ηλικίας αποτέλεσε ένα σημαντικό ζήτημα, ιδιαίτερα την περίοδο των αυξημένων προσφυγικών ροών. Πολλοί πρόσφυγες δήλωναν και δηλώνουν μικρότερη ηλικία προκειμένου να έχουν τα προνόμια που εξασφαλίζονται από τη *Διεθνή Σύμβαση για τα Δικαιώματα του Παιδιού* (Unicef, n.d.). Παρατηρείται δε και το αντίθετο φαινόμενο, δηλαδή ανήλικοι πρόσφυγες να δηλώνουν μεγαλύτερη ηλικία προκειμένου να αποφύγουν τη διαμονή σε δομές και να αναζητήσουν εργασία βοηθούμενοι από ομοεθνείς τους. Για το λόγο αυτό, ο καθορισμός της ηλικίας έχει απασχολήσει ιδιαίτερα τα κράτη. Η Ευρωπαϊκή Ένωση προσπαθεί να επιλύσει το πρόβλημα με διαδικασίες καθορισμού της ηλικίας (age assessment), έτσι ώστε να διασφαλιστούν στο μέγιστο τα δικαιώματα των παιδιών (European Union Agency for Asylum, 2022). Στην ανασκόπηση θεωρήσαμε ως δεδομένη την ηλικία των συμμετεχόντων που αναφέρει η εκάστοτε έρευνα.

Η ανασκόπηση κατέδειξε ότι οι δημοσιευμένες έρευνες που περιλαμβάνουν παρεμβάσεις μουσικής ή/και χορού για ανήλικους πρόσφυγες είναι σχετικά σπάνιες. Επιπρόσθετα, διαπιστώθηκε

πως η πλειοψηφία των ερευνών αφορούν στο πεδίο της θεραπείας. Αυτές οι μελέτες χρησιμοποιούν όρους όπως *χοροθεραπεία* (Dance/Movement Therapy, DMT) και *μουσικοθεραπεία* ή ως μέρος μιας ευρύτερης ομπρέλας με ποικίλες ορολογίες, όπως *θεραπεία μέσω των τεχνών* (Art Therapy) (Gray, 2011· Malchiodi, 2011· Rousseau et al., 2005· Ugurlu et al., 2016), *θεραπεία εκφραστικών τεχνών* (Expressive Arts Therapy, EXA) (Malchiodi, 2011· Meyer DeMott et al., 2017) ή *θεραπεία δημιουργικών τεχνών* (Creative Arts Therapy, CAT) (Dieterich-Hartwell & Koch, 2017· Gray, 2011· Harris, 2009· Quinlan et al., 2016· van Westrhenen & Fritz, 2014). Παρότι σε επίπεδο μέσων, πρακτικών και στοχοθεσίας παρατηρούνται κοινά σημεία ανάμεσα στα καλλιτεχνικά κοινοτικά και τα θεραπευτικά προγράμματα, αποφασίστηκε η παρούσα μελέτη να εστιάσει αποκλειστικά στις δράσεις μουσικής και χορού με κοινοτικό προσανατολισμό, αποκλείοντας τις έρευνες που προσδιορίζουν τις υπό μελέτη παρεμβάσεις ως θεραπευτικές.

Εντοπίστηκαν συνολικά 32 έρευνες εκ των οποίων δύο αφορούν παρεμβάσεις χοροθεραπείας, οκτώ παρεμβάσεις μουσικοθεραπείας, επτά προγράμματα δημιουργικών – εκφραστικών τεχνών συμπεριλαμβανομένου της μουσικής ή/και του χορού και 15 κοινοτικά προγράμματα μουσικής ή/και χορού. Αποκλείστηκαν έρευνες οι οποίες: α) είναι γραμμένες σε διαφορετική γλώσσα από την ελληνική ή την αγγλική, β) αφορούν τον χώρο της θεραπείας, γ) δεν περιλαμβάνουν παρέμβαση, αλλά αφορούν τη θεωρητική παρουσίαση του θέματος και δ) αποτελούν πτυχιακές ή μεταπτυχιακές μη δημοσιευμένες εργασίες.

Ως αποτέλεσμα, στην ανασκόπηση συμπεριλήφθηκαν τελικά 15 μελέτες. Οι επτά από αυτές αξιοποιούν και τις δύο τέχνες, μουσικής και χορού (Dhillon et al., 2020· Hundertmark, 2019· Marsh, 2012· Marsh & Dieckmann, 2017· Migliarini, 2020· Nicolaou et al., 2023· Storsve et al., 2012). Οι έξι βασίζονται αποκλειστικά την τέχνη της μουσικής (Broske-Danielsen, 2013· Crawford, 2020· Howell, 2011· Kenny, 2018· Millar & Warwick, 2019· Rosen & Shoenberger, 2020), μία είναι βασισμένη στην κίνηση (Bleile et al., 2021) και μία στο χορό-δημιουργική κίνηση (Dhillon & Ulmer, 2021). Όσον αφορά τους συμμετέχοντες/ουσες στις παρεμβάσεις τις οποίες μελετούν, πέντε εστιάζουν σε παιδιά πρόσφυγες (Howell, 2011· Kenny, 2018· Marsh & Dieckmann, 2017· Nicolaou et al., 2023· Rosen & Shoenberger, 2020), επτά σε έφηβους πρόσφυγες (Crawford, 2020· Dhillon et al., 2020· Dhillon & Ulmer, 2021· Marsh, 2012· Migliarini, 2020· Millar & Warwick, 2019· Storsve et al., 2010), ενώ δύο απευθύνονται σε προσφυγικό πληθυσμό εφηβικής και νεανικής ηλικίας (Bleile et al., 2021· Hundertmark, 2019). Τέλος, σε μία από τις έρευνες το δείγμα αποτελείται από φοιτητές μουσικής εκπαίδευσης, οι οποίοι πραγματοποίησαν μουσική εμφύχωση σε παιδιά πρόσφυγες (Broske-Danielsen, 2013).

ΚΑΤΗΓΟΡΙΟΠΟΙΗΣΗ ΚΑΙ ΑΝΑΛΥΣΗ ΕΡΕΥΝΩΝ

Οι 15 επιλεγμένες, σύμφωνα με τα κριτήρια, έρευνες μελετήθηκαν διεξοδικά και κατηγοριοποιήθηκαν. Η διαδικασία κατηγοριοποίησης έγινε αρχικά εστιάζοντας στο ιδιαίτερο ερευνητικό ενδιαφέρον και λαμβάνοντας υπόψη τα ερευνητικά ερωτήματα. Προέκυψαν τρεις βασικές κατηγορίες, οι οποίες διαφοροποιούν τις έρευνες με βάση το περιεχόμενο των παρεμβάσεων. Αυτές είναι οι εξής: α) παρεμβάσεις στις οποίες εντοπίστηκε μουσικοχορευτικό περιεχόμενο, β) παρεμβάσεις που εστίασαν μόνο στη μουσική και γ) παρεμβάσεις με περιεχόμενο που αφορούσε αποκλειστικά την κίνηση-χορό. Τόσο ο χορός όσο και η μουσική ως περιεχόμενα

των παρεμβάσεων αντιμετωπίστηκαν ως κοινοτικές τέχνες. Δηλαδή, οι παρεμβάσεις αντιμετωπίστηκαν ως κοινοτική μουσική και κοινοτικός χορός, είτε προσδιορίζονται έτσι από τους συγγραφείς των άρθρων, είτε όχι. Η επιλογή αυτή έγινε προκειμένου να μπορέσουν να συζητηθούν τα ερευνητικά αποτελέσματα με βάση μια γενικότερη θεωρητική και πρακτική πλαισίωση ευρύτερα αποδεκτή. Οι εννοιολογικοί προσδιορισμοί όπως έχουν ήδη αναφερθεί, δικαιολογούν αυτήν την επιλογή.

Με βάση αυτή την κατηγοριοποίηση γίνεται και η περιγραφική παρουσίαση στη συνέχεια του άρθρου. Αρχικά, μελετήθηκε το πλήρες κείμενο των άρθρων. Η μελέτη έγινε με δύο τρόπους, οι οποίοι διενεργήθηκαν σε σύγκριση και από κοινού. Ο πρώτος εστίασε στη μέθοδο κάθε έρευνας και τα αποτελέσματά της. Επιχειρήθηκε η κριτική αντιμετώπιση και ο εντοπισμός πιθανών ελλειμμάτων με στόχο την απόδοση σημαντικότητας στα αποτελέσματα. Ο δεύτερος τρόπος αντιμετώπισε το περιεχόμενο των άρθρων, τα οποία αναγνώστηκαν ως κείμενα προς θεματική ανάλυση και αναζητήθηκαν κοινά νοήματα, έννοιες, πρακτικές και επιδιώξεις. Ωστόσο, η εστίαση παρέμεινε στα ζητήματα εκείνα που μπορούν να απαντήσουν στα συγκεκριμένα ερευνητικά ερωτήματα (Braun & Clarke, 2012). Με τον τρόπο αυτό επιχειρήθηκε να εντοπιστεί η επίδραση των ερευνών στους ανήλικους πρόσφυγες, ώστε να απαντηθεί και το δεύτερο ερευνητικό ερώτημα.

Η διαδικασία ακολούθησε επαγωγικό συλλογισμό, ξεκινώντας από τις ειδικές και συγκεκριμένες έννοιες και θέματα που αναφέρονταν σε κάθε άρθρο προς τον προσδιορισμό των γενικών θεμάτων (Hsieh & Shannon, 2005). Διαπιστώθηκαν διαφοροποιήσεις ως προς την απόδοση νοήματος στις εντοπισμένες έννοιες, με βάση τη θεωρητική πλαισίωση και ερευνητική κατεύθυνση κάθε άρθρου. Για το λόγο αυτό, διενεργήθηκαν πολλαπλές αναγνώσεις με παράλληλη κωδικοποίηση των εννοιών και συνεχή σύγκριση. Οι βασικές προκλήσεις που αντιμετωπίστηκαν σε αυτή τη διαδικασία ήταν οι πολλές προσεγγίσεις στη συνολική ερευνητική διαδικασία, η ποικιλία στα πλαίσια διεξαγωγής των ερευνών, καθώς και η μεγάλη διαφορετικότητα που παρατηρείται στους προσφυγικούς πληθυσμούς.

ΠΑΡΟΥΣΙΑΣΗ ΤΩΝ ΕΡΕΥΝΩΝ

A. Έρευνες κοινοτικών παρεμβάσεων με μουσικό κα χορευτικό περιεχόμενο

Οι έρευνες οι οποίες αξιοποιούν και τις δύο τέχνες, χορού και μουσικής, αποτελούν την πλειοψηφία. Παρόλα αυτά σε δύο από αυτές ο χορός δεν εμφανίζεται στον τίτλο, παρά μόνο στο περιεχόμενο των παρεμβάσεων ως μουσικό γεγονός.

Η Marsh (2012) πραγματοποίησε έρευνα πεδίου σε σχολείο της Αυστραλίας με στόχο να διερευνήσει την επίδραση της μουσικής και του χορού στην ευζωία ανήλικων προσφύγων και μεταναστών. Πρόκειται για μια μελέτη περίπτωσης, στην οποία συμμετείχαν έφηβοι μετανάστες και πρόσφυγες ηλικίας 12-18 ετών. Η παρέμβαση είχε διάρκεια επτά μηνών και οι συναντήσεις λάμβαναν χώρα τουλάχιστον μία φορά την εβδομάδα. Οργανώθηκαν μαθήματα μουσικής και χορού και συγκεκριμένα σύνολα ορχήστρας, χορωδίας και hip hop χορού, καθώς και ποικίλες δημιουργικές και συνεργατικές δράσεις, μεταξύ των άλλων και η οργάνωση παραστάσεων. Ως μέσα συλλογής δεδομένων χρησιμοποιήθηκαν η παρατήρηση, οι αναφορές των διαμεσολαβητών, καθώς και άτυπες ή ημιδομημένες ομαδικές συνεντεύξεις με τη μορφή ομάδων εστίασης. Σύμφωνα με τη

Marsh, το πρόγραμμα είχε θετική επίδραση στους συμμετέχοντες και συμμετέχουσες. Πιο συγκεκριμένα, συνέβαλε στην ενίσχυση της αίσθησης της επιτυχίας και του ανήκειν, καθώς και την παροχή ευκαιριών για ενσώματες μορφές επικοινωνίας, ομαλότερη διαδικασία επιπολιτισμού και συμπερίληψης.

Οι Storsve et al. (2012) οργάνωσαν ένα πρόγραμμα κοινοτικής μουσικής με στόχο την προαγωγή της υγείας και του πολιτισμού, το οποίο απευθύνθηκε σε προσφυγόπαιδα στο Λίβανο. Το πρόγραμμα πραγματοποιήθηκε σε συνεργασία με το νορβηγικό οργανισμό υγείας *NORWAC* και το *Norwegian Academy of Music* με συμμετέχοντες ανήλικους πρόσφυγες από την Παλαιστίνη, οι οποίοι φιλοξενούνταν σε δομή υποδοχής. Το πρόγραμμα ξεκίνησε το 2002 και το 2005 η υλοποίησή του απέκτησε σταθερότητα με εβδομαδιαία συχνότητα. Τις παρεμβάσεις ανέλαβαν ντόπιοι εκπαιδευτικοί σύμφωνα με τις υποδείξεις των νορβηγών συναδέλφων τους ως προς το ρεπερτόριο, τις πρακτικές και τις μεθόδους διδασκαλίας. Το περιεχόμενο των δράσεων περιείχε ομαδικές δράσεις ορχήστρας, μουσικής επιτέλεσης με μελωδικά και ρυθμικά κρουστά και παραδοσιακού παλαιστινιακού χορού. Ιδιαίτερη βαρύτητα δόθηκε στις αλληλοδιδασκτικές πρακτικές και μεθόδους. Στο άρθρο τους οι συγγραφείς συζητούν τη γενικότερη πορεία και επίδραση του προγράμματος. Ωστόσο, δεν χρησιμοποιούν κάποια συγκεκριμένη επιστημονική μέθοδο παρακολούθησης, αξιολόγησης ή εκτίμησης των αποτελεσμάτων του προγράμματος. Βέβαια, η διάρκεια του προγράμματος και η συστηματική και κριτική περιγραφή του παρέχουν αρκετές πληροφορίες. Όμως, η ρευστότητα του προσφυγικού πληθυσμού, την οποία οι συγγραφείς σημειώνουν, και κυρίως έλλειψη ερευνητικής μεθοδολογίας μπορούν να θέσουν υπό αμφισβήτηση τις πληροφορίες αυτές και τη γενικότερη συζήτηση. Σύμφωνα με τους μελετητές, το πρόγραμμα είχε θετική επίδραση στην ψυχική υγεία των συμμετεχόντων, καθώς παρείχε ευκαιρίες για συναισθήματα χαράς, επιτυχίας και αναγνώρισης. Παράλληλα, συνεισέφερε στην ανακατασκευή της ταυτότητας, την απόκτηση συναισθηματικής ευελιξίας, την ανάπτυξη της αυτό-έκφρασης, της αίσθησης ελέγχου, της αυτοπεποίθησης και της ικανότητας επίλυσης προβλημάτων. Αναφορά γίνεται επίσης στα μουσικά οφέλη, δηλαδή την ανάπτυξη γενικών και ειδικών μουσικών δεξιοτήτων και την κατάκτηση γνώσης.

Σε έρευνα που πραγματοποίησαν σε σχολείο πρωτοβάθμιας εκπαίδευσης της Αυστραλίας, οι Marsh και Dieckmann (2017) εξέτασαν κατά πόσο τα μουσικά παιχνίδια και τα παιχνιδοτραγούδα ενδέχεται να συμβάλλουν στην κοινωνική ένταξη και συνοχή προσφύγων και νεοαφιχθέντων μεταναστών. Η έρευνα αποτέλεσε τμήμα μίας μελέτης πολλαπλών περιπτώσεων εθνογραφικού χαρακτήρα. Σε αυτή έλαβαν μέρος 619 παιδιά πρόσφυγες και πρόσφατα εγκαταστημένοι μετανάστες ηλικίας από έξι έως 12 ετών. Η συλλογή των δεδομένων βασίστηκε σε βιντεοσκοπήσεις, παρατήρηση και άτυπες συνεντεύξεις. Αντικείμενο παρατήρησης αποτέλεσαν σχολικά μαθήματα χορωδίας, ομαδικού τραγουδιού και χορού-κίνησης, πρόβες και παραστάσεις και επιπρόσθετα παιχνιδοτραγούδα από τις χώρες καταγωγής των μαθητών κατά το ελεύθερο παιχνίδι τους.

Τα αποτελέσματα κατηγοριοποιήθηκαν και αναλύθηκαν. Τα παιδιά εκδήλωσαν περιορισμένο ενδιαφέρον για χορωδιακές και δομημένες μουσικές δραστηριότητες, ενώ μεγάλο ενδιαφέρον έδειξαν για το μουσικό παιχνίδι και τα παιχνιδοτραγούδα. Φαίνεται πως η έλλειψη σημασιολογικού περιεχομένου των κειμένων τους, η απλότητα, η δυνατότητα εκμάθησης μέσω μίμησης, καθώς και το γεγονός ότι η κίνηση αποτελεί χαρακτηριστικό τους, διευκολύνει τη συμμετοχή και παρέχει

ευκαιρίες για άτυπο πολιτισμικό διάλογο και αποδοχή της διαφορετικότητας. Οι Marsh και Dieckmann φτάνουν στο συμπέρασμα πως η διεργασία του μουσικού παιχνιδιού και της επιτέλεσης των παιχνιδοτραγουδών συμβάλλουν στην ενίσχυση της αισιοδοξίας και της αυτοπεποίθησης, ενώ παράλληλα βοηθούν στην επαναδιαπραγμάτευση της ταυτότητας μέσα από την απόκτηση νέων ταυτοτήτων. Για το λόγο αυτό, προτείνουν τη συμπερίληψη των παιχνιδοτραγουδών στο επίσημο αναλυτικό πρόγραμμα με την ελπίδα ότι αυτό μπορεί να συμβάλλει στην ενίσχυση της κοινωνικής συνοχής στο ευρύτερο σχολικό περιβάλλον.

Η Hundertmark (2019) διερευνά τους στόχους και τους λόγους συμμετοχής εφήβων προσφύγων σε μια μουσικοχορευτική ομάδα, η οποία ιδρύθηκε από νεαρούς ενήλικες με προσφυγικό υπόβαθρο στη Γερμανία. Για την εν λόγω μελέτη επιλέχθηκε μια ομάδα τραγουδιού και χορού, στην οποία συμμετείχαν Σύριοι πρόσφυγες κάτω των 24 ετών. Πρόκειται για μια μελέτη περίπτωσης που επιπρόσθετα μελετά κατά πόσο η επιτέλεση της μουσικής και του χορού μπορούν να συμβάλλουν στον επιπολιτισμό στη χώρα υποδοχής και στην κοινωνικό-πολιτισμική συμπερίληψη. Τα ερευνητικά δεδομένα προέκυψαν από έξι συμμετέχοντες από 14 έως 24 ετών, οι οποίοι δέχτηκαν να παραχωρήσουν ημιδομημένη συνέντευξη και από τη συμμετοχική παρατήρηση μιας παράστασης της ομάδας. Όλοι οι νεαροί Σύριοι ανέφεραν ότι η ομάδα αποτελεί πηγή ευχαρίστησης και ενδυνάμωσης. Οι ερευνητές καταλήγουν πως η μεταμορφωτική δύναμη της μουσικής διευκολύνει την κοινωνικοπολιτισμική ένταξη στη χώρα υποδοχής και τη διαπολιτισμική κατανόηση. Επίσης, σύμφωνα με τα συμπεράσματα της έρευνας, δημόσιες εκδηλώσεις όπως οι παραστάσεις, βοηθούν τους νεαρούς πρόσφυγες να κερδίσουν αναγνώριση ως νεαροί μουσικοί, γεγονός που τους διευκολύνει κατά τη διαδικασία μετεγκατάστασής τους. Οι ερευνητές παραδέχονται ότι τα ευρήματα μιας μελέτης περίπτωσης δεν γενικεύονται, αλλά αναδεικνύουν τη μεταμορφωτική δύναμη της μουσικής και την αξία της πολιτικής κίνησης ίδρυσης μιας μουσικοχορευτικής ομάδας για πρόσφυγες από ενήλικες με προσφυγικό παρελθόν σε μια χώρα σαν τη Γερμανία.

Μέσα από μία εθνογραφική έρευνα, οι Dhillon et al. (2020) επιχειρούν να αποτυπώσουν την εμπειρία προσφύγων που έλαβαν μέρος σε κοινοτικό πρόγραμμα χορού και μουσικής, κύκλου κρουστών (drumming circle) και άλλων ποικίλων καλλιτεχνικών δράσεων. Το πρόγραμμα έλαβε χώρα στον Καναδά και λειτούργησε ως μια λέσχη μετά το σχολικό ωράριο με καθημερινές τετράωρες συναντήσεις για οκτώ μήνες. Στις συναντήσεις συμμετείχαν 59 συνολικά νέοι και νέες, εκ των οποίων 17 ήταν πρόσφυγες 11-18 ετών από εννέα διαφορετικές χώρες. Η έρευνα, παίρνοντας ως δεδομένο ότι η κίνηση και φυσική δραστηριότητα είναι ένα πανανθρώπινο φαινόμενο, εξετάζει πόσο σημαντική μπορεί να είναι η ομαδική συμμετοχή σε αυτή μέσα από μια ευρεία γκάμα κινητικών - χορευτικών και μουσικών δραστηριοτήτων στον επιπολιτισμό των νεαρών προσφύγων και στην αποδοχή της διαφορετικότητας. Τα ερευνητικά δεδομένα συλλέχθηκαν κυρίως από παρατήρηση, εθνογραφικές συνεντεύξεις, συμμετοχική παρατήρηση και αφηγήσεις προσφύγων. Οι μελετητές τονίζουν πως προσπάθησαν να συλλέξουν τις αφηγήσεις των νεαρών προσφύγων στο νατουραλιστικό και ουσιαστικό περιβάλλον του κύκλου κρουστών. Επίσης, συμπεριέλαβαν τα καλλιτεχνικά αποτελέσματα των συναντήσεων στη διαδικασία ανάλυσης των ερευνητικών δεδομένων. Ακολούθησε επαγωγική ανάλυση με συνεχή σύγκριση, η οποία ανέδειξε τη σημασία της κίνησης ως εκφραστικού και διαπραγματευτικού μέσου, τη σημασία του κοινού ρυθμού και των καλλιτεχνικών δραστηριοτήτων. Οι ερευνητές κάνουν ιδιαίτερη αναφορά στον

κύκλο κρουστών. Στη συγκεκριμένη δράση οι συμμετέχοντες/ουσες λειτουργούν ως ενεργοί χορευτές, χρησιμοποιώντας και τη φωνή τους. Έτσι, βρίσκουν ένα πεδίο έκφρασης. Φαίνεται πως η εμπειρία συμμετοχής σε κοινές κινητικές και ρυθμικές δραστηριότητες προσφέρει ευκαιρίες για έκφραση, αλληλεπίδραση και ψυχαγωγία. Παράλληλα, ενισχύει την αυτοαποτελεσματικότητα, την αυτοπεποίθηση και την αίσθηση του ανήκειν, βοηθά στον επιπολιτισμό των προσφύγων και στη συνειδητοποίηση της διατομεακής ταυτότητας (intersectional identity). Αυτό σημαίνει πως οι νεαροί πρόσφυγες κατανοούν ότι διαθέτουν πολλά και διασταυρούμενα χαρακτηριστικά ταυτότητας, όπως ενδεικτικά η εθνικότητα, η φυλή, το φύλο, η τάξη, η θρησκεία κ.α., γεγονός που διαμορφώνει τομείς ή υποεαυτούς με τους οποίους λειτουργεί κατά περίπτωση κάθε άτομο (Sarah et al., 2018). Η έρευνα διακρίνεται από πληρότητα και μεθοδικότητα. Βέβαια, υπόκειται στους περιορισμούς μιας μελέτης περίπτωσης και δεν αναφέρεται ιδιαίτερα στην εμπειρία των νέων που ανήκουν στη χώρα υποδοχής και συμμετείχαν στο πρόγραμμα.

Η Migliarini (2020), στην προσπάθειά της να διερευνήσει την επίδραση της μουσικής και του χορού στη διαμόρφωση της ταυτότητας προσφύγων με αναπηρία εφηβικής ηλικίας, οργάνωσε παρέμβαση μιας ημέρας, την οποία ονόμασε «I am Hip-Hop». Στην παρέμβαση αξιοποιήθηκε το Hip-Hop και Krip-Hop¹ ως ακτιβιστικές καλλιτεχνικές πρακτικές με ενταξιακό χαρακτήρα. Το περιεχόμενο της παρέμβασης αποτελούσαν από εργαστήρια breakdance, beat making, εξιστόρηση ιστοριών μέσα από στίχους (lyrical storytelling), open mic sessions² και τελική παράσταση. Η παρέμβαση έλαβε χώρα στην Ιταλία και σε αυτήν συμμετείχαν συνολικά 55 άτομα, εκ των οποίων 30 Ιταλοί έφηβοι, 20 έφηβοι πρόσφυγες ή μετανάστες στην πλειοψηφία τους διαγνωσμένοι με διαταραχή μετατραυματικού στρες (PTSD), διαταραχές συμπεριφοράς και μαθησιακές δυσκολίες. Συμμετείχαν επίσης και πέντε διαμεσολαβητές. Το μοντέλο έρευνας έχει στοιχεία έρευνας δράσης γιατί δίνει σε ερευνητές και διαμεσολαβητές το ρόλο του ερευνητή. Ο σχεδιασμός περιλάμβανε δύο μέρη: την προετοιμασία, σημαντικό μέρος της οποίας ήταν η παρατήρηση των κοινοτήτων στις οποίες στη συνέχεια απευθύνθηκε το κάλεσμα και μια ολόημερη δράση. Οι συμμετέχοντες είχαν ευκαιρίες για ελεύθερη σωματική έκφραση, μη λεκτική επικοινωνία, συζήτηση και προβληματισμό γύρω από την αξία της διαφορετικότητας και την hip-hop κουλτούρα. Τα δεδομένα προήλθαν από αναφορές συμμετοχικής παρατήρησης, βιντεοσκοπήσεις και εργαστήρια δημιουργικής γραφής, τα οποία αποτέλεσαν μέρος της δράσης. Το ιδιαίτερο ενδιαφέρον της έρευνας είναι πως ασχολείται και με άτομα με αναπηρία. Η Migliarini καταλήγει πως τα Hip-Hop και Krip-Hop δύνανται να δημιουργήσουν ένα ασφαλές περιβάλλον για ανταλλαγή εμπειριών, έκφραση της «φωνής» των συμμετεχόντων και συμπερίληψη, ενώ επίσης να εγείρουν κριτικά ερωτήματα για τις κοινωνικές ανισότητες στα σχολικά περιβάλλοντα. Όμως, το συμπέρασμα αυτό μπορεί να αξιοποιηθεί μάλλον μόνο ως μια σοβαρή ένδειξη. Η μονοήμερη διάρκεια της παρέμβασης και το περιεχόμενό της παραπέμπουν περισσότερο σε μια

¹ Το Krip-Hop είναι ένα καλλιτεχνικό κίνημα, μέσω του οποίου hip hop καλλιτέχνες με αναπηρίες μπορούν να επικοινωνήσουν με τα κοινωνικά δίκτυα. Αξιοποιεί τη μουσική hip hop ως μέσο έκφρασης για ανθρώπους με αναπηρία, προσφέροντάς τους ευκαιρίες να μοιραστούν τις εμπειρίες τους. https://en.wikipedia.org/wiki/Krip_Hop

² Το open mic (ή open mike) sessions αναφέρεται σε παραστάσεις που πραγματοποιούνται σε ένα χώρο εστίασης, όπου τα μέλη του κοινού μπορούν να εμφανιστούν σε σκηνή είτε είναι ερασιτέχνες είτε επαγγελματίες, συχνά για να προωθήσουν μια επερχόμενη παράσταση. Τα open mics εστιάζουν στις παραστατικές τέχνες, όπως κωμωδία (sketch ή stand-up), μουσική, ποίηση κ.α. https://en.wikipedia.org/wiki/Open_mic

ακτιβιστική ενέργεια που ταυτόχρονα μελετάται και αναλύεται. Το θέμα, βέβαια, είναι ενδιαφέρον, αλλά χρήζει περαιτέρω διερεύνησης προκειμένου να τοποθετηθούμε στην αξιοποίηση του Hip-Hop και Krip-Hop στην ευρύτερη εκπαίδευση, συμπερίληψη και επιπολιτισμό νεαρών προσφύγων με ή χωρίς αναπηρία.

Οι Nicolaou et al. (2023) διερεύνησαν την επίδραση μιας παρέμβασης σε κέντρο φιλοξενίας αιτούντων άσυλο στην Ολλανδία. Αξιοποιήθηκε η μέθοδος της έρευνας δράσης προκειμένου να διερευνηθεί μια πρακτική, η οποία βασίζεται στη διευκόλυνση της συμμετοχής σε μουσικές και χορευτικές δραστηριότητες με παιδιά πρόσφυγες που αιτούνται άσυλο. Η παρέμβαση ολοκληρώθηκε σε τέσσερις συναντήσεις διάρκειας 60 έως 120 λεπτών στο διάστημα ενός μήνα. Σε αυτές συμμετείχαν 11 παιδιά ηλικίας έξι-11 ετών με τόπο καταγωγής την Ερυθραία, το Ιράν, τη Ρωσία, τη Συρία και την Τουρκία. Το περιεχόμενο της παρέμβασης καταγράφεται συστηματικά και δίνει ιδιαίτερη σημασία σε δημιουργικές δραστηριότητες, όπως ο αυτοσχεδιασμός, η σύνθεση και η έκφραση. Η συλλογή δεδομένων έγινε μέσα από βιντεοσκοπήση, ηχογραφήσεις, ημερολόγιο ερευνητή και τους αναστοχαστικούς σχολιασμούς του καλλιτεχνικού διαμεσολαβητή μετά από κάθε συνάντηση και κατά τη διάρκεια παρακολούθησης των βιντεοσκοπήσεων. Τα ερευνητικά αποτελέσματα αναδεικνύουν τη σημασία της μη λεκτικής επικοινωνίας και των δημιουργικών δραστηριοτήτων στην εκπαίδευση και προσωπική ανάπτυξη των προσφυγόπαιδων. Τονίζεται, επίσης, ο καθοριστικός ρόλος του διαμεσολαβητή/τριας, καθώς και η ανάγκη ενός ευέλικτου μη γραμμικού σχεδιασμού των εργαστηρίων της παρέμβασης που να επιτρέπει τη συνδιαμόρφωση του περιεχομένου. Οι ερευνητές δίνουν με ολοκληρωμένο τρόπο ένα παράδειγμα παρέμβασης και τη θεωρητική του πλαισίωση και αυτό είναι θετικό. Ωστόσο, καταλήγουν στη λειτουργικότητα και τα θετικά αποτελέσματά του μέσα από μια έρευνα δράσης χρονικά περιορισμένης. Όπως και οι ίδιοι παραδέχονται, η διάρκεια του προγράμματος είναι μικρή και δε διευκολύνει τη οικοδόμηση διαπροσωπικής σχέσης μεταξύ διαμεσολαβητή-συμμετεχόντων, η οποία θα μπορούσε να ενισχύσει την περεταίρω ανάπτυξη μιας καλλιτεχνικής δημιουργικής συμπεριφοράς.

Β. Έρευνες παρεμβάσεων με μουσικό περιεχόμενο

Η έρευνα της G. Howell (2011) επικεντρώνεται στην αξιοποίηση της μουσικής ως μέσου προσωπικής και κοινωνικής ενδυνάμωσης στο πλαίσιο του μαθήματος μουσικής σε ένα σχολείο εκμάθησης της αγγλικής γλώσσας στην Αυστραλία. Αξιοποιεί δημιουργικές μουσικές διαδικασίες, ιδιαίτερα τη συνεργατική σύνθεση τραγουδιών και διερευνά τον τρόπο συμμετοχής σε αυτές, καθώς και τα οφέλη. Το μάθημα απευθύνεται σε νεοαφιχθέντες πρόσφυγες και μετανάστες μαθητές και μαθήτριες από διαφορετικές πολιτισμικές και γλωσσικές κοινότητες ηλικίας 8-14 ετών με διαφορετικό επίπεδο εξοικείωσης στη γλώσσα και στο νέο πολιτισμικό πλαίσιο. Ως μέσα συλλογής δεδομένων χρησιμοποιήθηκαν η παρατήρηση και η συνέντευξη με συνδρομή διερμηνέα σε τρεις μαθητές με καταγωγή από το Σουδάν, την Κίνα και την Ταϊλάνδη και μία εκπαιδευτική γενικής εκπαίδευσης. Όπως δείχνουν τα αποτελέσματα της έρευνας, τα μη λεκτικά μέσα μπορούν να διευκολύνουν τη συμμετοχή των παιδιών στη δημιουργική διαδικασία και να μειώσουν τη σύγχυση που δημιουργεί η έλλειψη κοινής γλώσσας ή πολιτισμικών αναφορών, χωρίς να αναιρείται πως όσο αυξάνεται η κατανόηση της γλώσσας τόσο αυξάνεται και η συμμετοχή στη δημιουργική διαδικασία. Η συγγραφέας καταλήγει στο συμπέρασμα πως η μουσική μπορεί να προσφέρει

ευκαιρίες αυτοεπιβεβαίωσης, συνεισφέροντας έτσι στην ενίσχυση της αυτοπεποίθησης και της ψυχικής ανθεκτικότητας των μαθητών, ενώ ταυτόχρονα μπορεί να λειτουργήσει ως γέφυρα σύνδεσης και επικοινωνίας για μαθητές με διαφορετικό πολιτισμικό κεφάλαιο. Η έρευνα τονίζει την εκπαιδευτική και κοινωνική αξία της μουσικής. Παρ' όλα αυτά, υπάρχουν κενά στην ερευνητική διαδικασία. Δεν αναφέρεται ο ακριβής αριθμός των συμμετεχόντων, η διάρκεια της παρέμβασης και η συχνότητα των συναντήσεων, γεγονός που σε συνδυασμό με την ελλιπή περιγραφή των ερευνητικών δεδομένων περιορίζουν τη σημαντικότητα των αποτελεσμάτων.

Η Broeske-Danielsen (2013) διερεύνησε τις εμπειρίες 16 φοιτητών από το Norwegian Academy of Music αναφορικά με την πρακτική τους άσκηση, κατά τη διάρκεια της οποίας εφάρμοσαν δωδεκάημερο πρόγραμμα κοινοτικής μουσικής σε πρόσφυγες 7-20 ετών που διέμεναν στο κέντρο υποδοχής Rashedie στο Λίβανο. Οι μουσικές δραστηριότητες περιλάμβαναν σύνολα μουσικών οργάνων, παιδική ορχήστρα, πρόβες μουσικής σε όλο και μεγαλύτερες ομάδες και συναυλίες στο κέντρο υποδοχής και σε τοπικά σχολεία. Τα δεδομένα συλλέχθηκαν μέσω ημερολογίων με περιεχόμενο τους προβληματισμούς και τους αναστοχασμούς των φοιτητών σχετικά με την εμπειρία της πρακτικής άσκησης. Τα ημερολόγια αποτέλεσαν τη μοναδική πηγή ερευνητικών δεδομένων και παραδόθηκαν εντός τριών εβδομάδων μετά την πρακτική άσκηση. Η ερευνήτρια δεν αναφέρει τον τρόπο οργάνωσης των εν λόγω ημερολογίων. Η ανάλυση του περιεχομένου τους παρέχει πληροφορίες σχετικά με την επίδραση της πρακτικής άσκησης στους φοιτητές/τριες και όχι στις ομάδες των προσφυγόπαιδων που συμμετείχαν σε αυτή. Καταδεικνύει τη μοναδικότητα που κάθε μελλοντικός εκπαιδευτικός επιλέγει τις στρατηγικές του/της. Παρουσιάζει τη μεγάλη ποικιλία προκαταλήψεων, επιχειρηματολογίας και τρόπου συνεργασίας που προκύπτει. Όπως συνήθως κάθε πρακτική άσκηση, έτσι και η συγκεκριμένη ήταν ωφέλιμη για το σύνολο των συμμετεχόντων και παρείχε στους φοιτητές εφόδια για εξέλιξη της προσωπικής και επαγγελματικής τους ταυτότητας. Η προς διερεύνηση πρακτική άσκηση παρουσιάζει ενδιαφέρον, γιατί υλοποιήθηκε σε ένα κέντρο υποδοχής προσφύγων στο Λίβανο. Παρ' όλα αυτά, ο περιορισμός της συλλογής δεδομένων μόνο από μια πηγή, καθώς και οι μη επαρκείς πληροφορίες για την οργάνωση του ημερολογίου των φοιτητών και τη μορφή και οργάνωση της πρακτικής άσκησης αφήνουν κενά. Το ερώτημα πώς ο συγκεκριμένος μαθητικός πληθυσμός συνεισέφερε επιπλέον στην επαγγελματική ανάπτυξη των μελλοντικών εκπαιδευτικών δεν απαντάται επαρκώς. Επίσης, δεν εξετάζεται, μάλλον από ερευνητική επιλογή, η επίδραση της άσκησης στα παιδιά πρόσφυγες.

Η μελέτη των Millar και Warwick (2019) διερευνά τη σχέση της μουσικής με την ευημερία νέων προσφύγων από το Ιράκ στο πλαίσιο μίας παρέμβασης που πραγματοποιήθηκε σε προσφυγικό καταυλισμό στη Βόρεια Ελλάδα. Η έρευνα επικεντρώθηκε στα παιδιά που ανήκαν στην ιδιαίτερη κοινωνικο-θρησκευτική ομάδα των Γιαζίντι ηλικίας 11-18 ετών. Συμμετείχαν 12 νέα άτομα, τα οποίοι παρακολούθησαν ατομικά μαθήματα κιθάρας και ομαδικά εργαστήρια τραγουδιού για διάστημα πέντε εβδομάδων. Παρόλα αυτά, οι ερευνητές δηλώνουν πως η παρατήρηση και οι συνεντεύξεις αφορούν σε έξι από αυτά (τρία αγόρια και τρία κορίτσια). Τα δεδομένα συλλέχθηκαν μέσω συμμετοχικής παρατήρησης και ημιδομημένων συνεντεύξεων και αναλύθηκαν ποιοτικά, με βάση τέσσερις βασικές θεματικές κατηγορίες: συναισθήματα, αυτοπροσδιορισμός, κοινωνική αλληλεπίδραση και αυτονομία. Τα ευρήματα της μελέτης υποδεικνύουν ότι οι μουσικές δραστηριότητες αποτελούν σημαντικές πρακτικές προαγωγής της υγείας, καθώς δημιουργούν υποστηρικτικά περιβάλλοντα, ενισχύουν την πολιτισμική ανταλλαγή, προάγουν τη συμμετοχική

μάθηση και κοινωνικοποίηση. Ακόμη, αναδεικνύουν τη θετική συμβολή της μουσικής στη συναισθηματική έκφραση, τη βελτίωση των κοινωνικών σχέσεων, την ανάπτυξη αυτογνωσίας και αίσθησης του ανήκειν, το θετικό αυτοπροσδιορισμό και την ενίσχυση της αυτονομίας των συμμετεχόντων. Η αξία της έρευνας εντοπίζεται στη μελέτη νέων από ένα πληθυσμό με ιδιαίτερα κοινωνικά, θρησκευτικά και πολιτισμικά χαρακτηριστικά. Παρόλα αυτά, είναι περιορισμένη λόγω του μικρού αριθμού του δείγματος. Συνολικά, η έρευνα υπογραμμίζει τη δυναμική της μουσικής ως μέσου προαγωγής της προσωπικής και κοινωνικής ευημερίας ευάλωτων κοινωνικά ομάδων, όπως οι πρόσφυγες, αναδεικνύοντας τις ευκαιρίες που παρέχει για αναδιαμόρφωση της ταυτότητας, διαπολιτισμικό διάλογο και αλληλεπίδραση.

Η Crawford (2020) διερευνά την επίδραση της μουσικής και των τεχνών στη μάθηση, την κοινωνική και προσωπική ανάπτυξη των μαθητών με προσφυγικό υπόβαθρο. Πρόκειται για μια μελέτη περίπτωσης που αποτελεί μέρος μιας εθνογραφικής μελέτης πολλαπλών περιπτώσεων. Η ερευνήτρια επέλεξε να παρουσιάσει τη συγκεκριμένη, καθώς σε αυτή είχε διάρκεια δέκα εβδομάδων και επιπρόσθετα εξασφάλισε τη διαθεσιμότητα των συμμετεχόντων (n=20) να παραχωρήσουν συνέντευξη. Η έρευνα πραγματοποιήθηκε σε σχολείο δευτεροβάθμιας εκπαίδευσης στην Αυστραλία και οι συμμετέχοντες/ουσες ήταν μαθητές και μαθήτριες με προσφυγικό υπόβαθρο μεταξύ 13 και 17 ετών. Ενδιαφέρον παρουσιάζει το γεγονός ότι η συλλογή δεδομένων προήλθε, όχι μόνο από συνεντεύξεις και αξιολογήσεις του εκπαιδευτικού μουσικής, αλλά και άλλων εκπαιδευτικών του σχολείου. Επίσης, τα δεδομένα παρατήρησης προήλθαν από παρατήρηση όχι μόνο μαθημάτων μουσικής, αλλά και άλλων αντικειμένων. Με αυτόν τον τρόπο, το εκπαιδευτικό πλαίσιο λαμβάνει χώρα στην ερευνητική διαδικασία με ένα συνολικό και όχι αποσπασματικό τρόπο, ενώ ιδιαίτερη σημασία δίνεται στην πολιτισμική ανταλλαγή. Τα αποτελέσματα της έρευνας αναδεικνύουν τη σημαντικότητα της μουσικής για τους πρόσφυγες στο σχολικό πλαίσιο. Επιπρόσθετα, καταδεικνύουν το ρόλο της στα κίνητρα για μάθηση, ευχάριστα συναισθήματα, βελτίωση της αυτοεικόνας μέσα από απόκτηση νέων κοινωνικο-συναισθηματικών και μουσικών δεξιοτήτων. Παράλληλα, σύμφωνα με την ερευνήτρια, η μουσική δημιουργεί ευκαιρίες για αλληλεπίδραση και διάλογο μεταξύ των μαθητών, με αποτέλεσμα την επαναδιαπραγμάτευση των παλαιών και νέων πολιτισμικών ταυτοτήτων και βοηθά στην ανάπτυξη κοινωνικής συνοχής.

Η Kenny (2018) διερευνά την επίδραση της μουσικής σε παιδιά πρόσφυγες που διέμεναν στο κρατικό κέντρο κοινοτικής στέγασης για αιτούντες άσυλο «Direct Provision» της Ιρλανδίας. Στο πλαίσιο της έρευνας πραγματοποιήθηκε δίμηνο πρόγραμμα μουσικών εργαστηρίων, στο οποίο συμμετείχαν 11 παιδιά αιτούντες άσυλο ηλικίας 7-12 ετών. Το πρόγραμμα περιλάμβανε δραστηριότητες ακρόασης, μουσικής επιτέλεσης με κρουστά, φωνητικού αυτοσχεδιασμού, ομαδικού τραγουδιού και μουσικής σύνθεσης, καθώς επίσης και οργάνωση παραστάσεων. Η συλλογή των δεδομένων έγινε μέσα από βιντεοσκόπηση, παρατήρηση και συνεντεύξεις με τη μορφή ομάδων εστίασης και αναλύθηκαν με στόχευση σε τρεις άξονες, τους οποίους η ερευνήτρια επιλέγει βασισμένη στη μελέτη της βιβλιογραφίας. Αυτοί είναι η κοινότητα, η ταυτότητα και ο πολιτισμός. Τα αποτελέσματα δείχνουν ότι τα παιδιά πρόσφυγες βρίσκονται σε μια συνεχή πορεία επαναδιαπραγμάτευσης. Η πολυπλοκότητα του πολιτισμικού αποταμιεύματος που φέρουν, καθώς και των βιωμάτων τους, οδηγεί συχνά σε εσωτερικές συγκρούσεις. Η Kenny προτείνει τη μουσική πράξη και δημιουργία ως ένα επικοινωνιακό εργαλείο για τη βαθύτερη κατανόηση,

διαπραγμάτευση και αναδόμηση ταυτοτήτων, δημιουργώντας ευκαιρίες για αυτενέργεια και ανάπτυξη της αίσθησης του ελέγχου και του ανήκειν, ενίσχυση της κοινωνικής συνοχής και συμπερίληψης των συμμετεχόντων.

Οι Rosen και Shoenberger (2020) προσπαθούν να κατανοήσουν τον τρόπο με τον οποίο επιδρά η παρακολούθηση και η συμμετοχή σε μουσικές συναυλίες με πολυπολιτισμικό περιεχόμενο. Συγκεκριμένα, διερευνούν τον τρόπο που αυτές επηρεάζουν ποικίλες διαστάσεις της ζωής των παιδιών και τη σχολική κουλτούρα. Εστιάζουν δε στο κατά πόσον αυτό μπορεί να βοηθήσει παιδιά πρόσφυγες στη διαδικασία μετεγκατάστασής τους. Η έρευνα πραγματοποιήθηκε με τη συνεργασία ενός σχολείου της Πενσυλβάνια και ενός πανεπιστημιακού τμήματος, το οποίο οργάνωσε την ερευνητική ομάδα. Τα παιδιά του σχολείου προέρχονταν από 24 διαφορετικές χώρες και είχαν 15 διαφορετικές ομιλούμενες γλώσσες. Έξι συναυλίες πραγματοποιήθηκαν τόσο στο σχολείο όσο και στο πανεπιστήμιο κατά τη διάρκεια ενός έτους. Τα ερευνητικά δεδομένα προέρχονται από παρατήρηση, καταγραφή σημειώσεων και ημιδομημένες ατομικές ή ομαδικές συνεντεύξεις από 23 μαθητές και 11 μέλη του εκπαιδευτικού προσωπικού του σχολείου. Το πρόγραμμα φαίνεται να είχε κοινωνικο-συναισθηματικά οφέλη για τους μαθητές και θετική επίδραση στη σχολική κουλτούρα. Τονίζεται, επίσης, η θετική επίδραση από την επαφή σχολείου και πανεπιστημίου στη λειτουργία και των δύο φορέων. Η αδυναμία παραχώρησης ατομικών συνεντεύξεων λόγω σχολικού κανονισμού και ο περιορισμένος χρόνος σημειώνονται από τους συγγραφείς του άρθρου ως οι σημαντικότεροι περιορισμοί αυτής της έρευνας. Η συνεργασία διαφορετικών φορέων εκπαίδευσης και η συνολική αντιμετώπιση του σχολικού πλαισίου παρουσιάζουν ιδιαίτερο ενδιαφέρον και ανοίγουν δρόμους για περαιτέρω και συστηματικότερη διερεύνηση.

Γ. Έρευνες με παρέμβαση βασισμένη στην κίνηση-χορό

Η έρευνα των Bleile et al. (2021) είχε ως στόχο την αξιολόγηση μιας παρέμβασης βασισμένης στην κίνηση, η οποία αναφέρεται ως *TeamUp*. Η παρέμβαση πραγματοποιήθηκε σε 15 κέντρα υποδοχής αιτούντων άσυλο στην Ολλανδία. Ξεκίνησε τον Σεπτέμβριο του 2018 και ολοκληρώθηκε τον Ιούλιο του 2019. Σε αυτήν συμμετείχαν 2183 παιδιά ηλικίας 6-17 ετών και 81 εμψυχωτές. Η έρευνα ακολούθησε μεικτή μεθοδολογία, αξιοποιώντας ποσοτικές και ποιοτικές μεθόδους. Η συλλογή δεδομένων βασίστηκε σε συστηματική παρατήρηση, ερωτηματολόγια και συνεντεύξεις. Το εργαλείο παρατήρησης δημιουργήθηκε για να αξιολογήσει την ποιότητα της παρέμβασης, λαμβάνοντας υπόψη και τις ενέργειες των διαμεσολαβητών. Η αξιολόγηση της παρέμβασης βασίστηκε σε ερωτηματολόγιο, το οποίο απαντήθηκε από τα παιδιά πριν και μετά από την παρέμβαση. Οι κλειστού τύπου ερωτήσεις πενταβάθμιας κλίμακας Likert διερευνούσαν τις δυνατότητες αλληλεπίδρασης σε μια πολυπολιτισμική και πολύγλωσση ομάδα, καθώς και τη δυνατότητα των συμμετεχόντων σε αυτή να διαχειρίζονται προκλήσεις και να ελέγχουν τη συμπεριφορά τους. Οι διαμεσολαβητές κλήθηκαν να απαντήσουν ερωτηματολόγιο 45 ερωτήσεων, εκ των οποίων οι 25 ήταν κλειστές με μορφή πενταβάθμιας κλίμακας Likert. Ακολούθησε η στατιστική ανάλυση των δεδομένων. Οι ανοιχτές ερωτήσεις προς τους διαμεσολαβητές, τις οποίες οι ερευνητές χαρακτηρίζουν ως συνέντευξη, αναλύθηκαν με το λογισμικό Nvivo. Τα αποτελέσματα δείχνουν πως συνολικά οι δραστηριότητες κίνησης είχαν θετικό αντίκτυπο στην ψυχοκοινωνική μάθηση, την αλληλεπίδραση με συνομηλίκους και τη γενικότερη

ευημερία των παιδιών συμμετεχόντων, ενώ οι μεγαλύτερες προκλήσεις αφορούσαν σε θέματα διαχείρισης ενέργειας και προβληματικής συμπεριφοράς τους. Οι ερευνητές δεν δίνουν στοιχεία για τον τρόπο στάθμισης των ερωτηματολογίων που χρησιμοποίησαν. Χαρακτηρίζουν δε ως εργαλεία τις λίστες παρακολούθησης, τις οποίες οι διαμεσολαβητές τηρούν λεπτομερώς και οι ερευνητές ποσοτικοποιούν στο τέλος των παρεμβάσεων. Ο αριθμός του δείγματος και η διάρκεια της παρέμβασης προσδίδουν ιδιαίτερο ενδιαφέρον στην έρευνα. Οι μεικτές μεθοδολογίες έχουν, επίσης, μεγάλο ενδιαφέρον. Στη συγκεκριμένη έρευνα, όμως, παρατηρούνται κενά ως προς τον σχεδιασμό της ποσοτικής και της ποιοτικής προσέγγισης.

Η έρευνα των Dhillon και Ulmer (2021) επικεντρώθηκε στην αξιοποίηση του χορού και της δημιουργικής κίνησης για τη στήριξη νέων προσφύγων κατά τη διαδικασία προσαρμογής τους στο νέο περιβάλλον. Αναφέρεται ότι η παρέμβαση είχε εντατικό χαρακτήρα και ήταν πολυήμερη, χωρίς να δίνονται λεπτομέρειες. Στην έρευνα συμμετείχαν πρόσφυγες ηλικίας 13-18 ετών με καταγωγή από Αιθιοπία, Ιράκ, Σουδάν και Συρία και άλλες χώρες. Κύριος στόχος ήταν να εξεταστεί πώς οι νέοι πρόσφυγες μπορούν να εκφράσουν προσωπικές τους εμπειρίες και να αναπτύξουν μια αίσθηση πολιτισμικής σύνδεσης με τη νέα κοινότητα μέσω μιας σειράς δραστηριοτήτων οπτικής βιογραφίας. Το περιεχόμενο της παρέμβασης είναι πολυμεσικό και πρωτότυπο. Οι συμμετέχοντες κλήθηκαν να φωτογραφίσουν στιγμές από την καθημερινότητά τους και να τις συνδέσουν με συναισθηματικές και πολιτισμικές αναμνήσεις. Στη συνέχεια, οι φωτογραφίες αυτές χρησιμοποιήθηκαν για τη δημιουργία ενός κόμικ, το οποίο ολοκληρωνόταν με την προσθήκη κίνησης και μουσικής και κατέληγε στη δημιουργία συλλογικής παράστασης χορού. Οι συγγραφείς καταλήγουν στο συμπέρασμα πως οι δραστηριότητες δημιουργικής κίνησης μπορούν να προσφέρουν ευκαιρίες για βαθύτερη κατανόηση της ταυτότητας και σύνδεση με την τοπική κοινότητα, ενώ ταυτόχρονα φαίνεται να ενισχύουν το αίσθημα του ανήκειν σε αυτήν. Η πολυμεσικότητα του περιεχομένου δίνει τη δυνατότητα μιας εις βάθος κατανόησης των εμπειριών των συμμετεχόντων και παρέχει ευέλικτο και προσαρμόσιμο μοντέλο δημιουργικής κίνησης, κατάλληλο για διαφορετικά περιβάλλοντα και ομάδες. Παρά την καινοτομία της παρέμβασης, το άρθρο δεν αναφέρει τον ακριβή αριθμό των συμμετεχόντων, τη διάρκεια της παρέμβασης και τη συχνότητα των συναντήσεων, γεγονός που περιορίζει τη δυνατότητα αξιολόγησης της έρευνας και της γενικευσιμότητας των ευρημάτων.

ΣΥΖΗΤΗΣΗ – ΣΥΜΠΕΡΑΣΜΑΤΑ

A. Ως προς το περιεχόμενο των κοινοτικών προγραμμάτων

Όπως ήδη αναφέρθηκε, η βιβλιογραφική αναζήτηση δείχνει ότι οι περισσότερες έρευνες έχουν μουσικοθεραπευτικό και χοροθεραπευτικό χαρακτήρα. Επίσης, αξιοποιούν τις τέχνες συνολικά και όχι ξεχωριστά. Διαπιστώνεται, επίσης, πως μόνο μία μελέτη αξιοποιεί αποκλειστικά την τέχνη του χορού (Dhillon & Ulmer, 2021), παρά το γεγονός ότι ο κοινοτικός χορός είναι ιδιαίτερα διαδεδομένος (Amans, 2008). Ο χορός φαίνεται να λειτουργεί συμπληρωματικά σε ορισμένα προγράμματα μουσικής για ανήλικους πρόσφυγες ή να γίνεται κατανοητός ως μουσική παράμετρος (Marsh, 2012· Marsh & Dieckmann, 2017· Storsve et al., 2012) ή ως κίνηση και όχι ως τέχνη (Bleile et al., 2021· Nicolaou et al., 2023). Συγκεκριμένα, παρατηρείται ότι σε τρεις έρευνες (Marsh, 2012· Marsh &

Dieckmann, 2017· Storsve et al., 2012) οι παρεμβάσεις χαρακτηρίζονται από τους συγγραφείς ως καθαρά μουσικές, παρότι ο χορός και η κίνηση αποτελούν κομμάτι των δραστηριοτήτων και των παρουσιάσεων του προγράμματος. Στα προγράμματα που περιλαμβάνουν τόσο μουσικά όσο και χορευτικά-κινητικά στοιχεία, φαίνεται πως η μουσική και ο χορός-κίνηση αντιμετωπίζονται ως μία ενότητα. Αυτό μπορεί να δικαιολογηθεί, καθώς η συνύπαρξη του χορού και της μουσικής στην ανθρώπινη δραστηριότητα είναι απόλυτα φυσικό και πανανθρώπινο φαινόμενο.

Στις περισσότερες έρευνες δεν κατονομάζεται το είδος μουσικής και χορού που χρησιμοποιήθηκε. Παρόλα αυτά, σε πέντε προγράμματα αξιοποιήθηκε πολιτισμικό υλικό (τραγούδια, παιχνιδοτραγούδα, παραδοσιακοί χοροί) από τη χώρα καταγωγής των συμμετεχόντων (Crawford, 2020· Hundertmark, 2019· Marsh & Dieckmann, 2017· Rosen & Shoenberger, 2020· Storsve et al., 2012), ενώ σε ένα τραγούδι από το ιδιαίτερο κοινωνικο-θρησκευτικό υπόβαθρο των Γιαζίντι και τραγούδια σύγχρονου δυτικού πολιτισμού (Millar & Warwick, 2019). Επιπρόσθετα, σε δύο έρευνες χρησιμοποιήθηκαν είδη χορού με συγκεκριμένη τεχνική και ύφος (breakdance, hip hop) (Marsh, 2012· Migliarini, 2020), δύο την προσέγγιση του δημιουργικού χορού (Dhillon et al., 2020· Dhillon & Ulmer, 2021), ενώ σε δύο αξιοποιήθηκε ποικιλία μουσικών ειδών ανάλογα με τις προτιμήσεις των συμμετεχόντων (Dhillon et al., 2020· Nicolaou et al., 2023).

Διαπιστώθηκε πως επτά έρευνες αξιοποίησαν την οργάνωση μουσικών συνόλων χορωδίας και ομαδικού τραγουδιού (Crawford, 2020· Hundertmark, 2019· Kenny, 2018· Marsh, 2012· Marsh & Dieckmann, 2017· Millar & Warwick, 2019· Nicolaou et al., 2023), τέσσερις τη δημιουργία συνόλων ορχήστρας και μουσικής πράξης (Broeske-Danielsen, 2013· Marsh, 2012· Rosen & Shoenberger, 2020· Storsve et al., 2012), έξι τη μουσική πράξη με κρουστά όργανα (Crawford, 2020· Dhillon et al., 2020· Kenny, 2018· Nicolaou et al., 2023· Rosen & Shoenberger, 2020· Storsve et al., 2012) και μία ατομικά μαθήματα οργάνου (Millar & Warwick, 2019). Επιπρόσθετα, τέσσερις έρευνες μελέτησαν δραστηριότητες που αφορούσαν τη μουσική σύνθεση (Crawford, 2020· Howell, 2011· Kenny, 2018· Nicolaou et al., 2023), μία στη σύνθεση beat (Migliarini, 2020), δύο στη συγγραφή στίχων (Howell, 2011· Migliarini, 2020), τρεις στην ενεργητική ακρόαση (Kenny, 2018· Migliarini, 2020· Rosen & Shoenberger, 2020), μία στη διασκευή τραγουδιών από τη χώρα καταγωγής (Hundertmark, 2019), δύο στο ρυθμικό και κινητικό αυτοσχεδιασμό (Dhillon et al., 2020· Nicolaou et al., 2023), δύο στο φωνητικό αυτοσχεδιασμό ή αυτοσχεδιασμό με ρίμες (Kenny, 2018· Migliarini, 2020) και μία στην οπτική βιογραφία με στοιχεία φωτογραφίας, κόμικ και μουσικής επένδυσης (Dhillon & Ulmer, 2021). Επισημαίνεται ότι τρεις έρευνες εστίασαν στη συνδιαμόρφωση του περιεχομένου με βάση τις προτιμήσεις των συμμετεχόντων μέσα από διαλογικές διαδικασίες και συνεχή ανατροφοδότηση (Crawford, 2020· Migliarini, 2020· Nicolaou et al., 2023). Υπογραμμίζεται επίσης ότι στις 12 από τις 15 μελέτες εμπεριέχεται οργάνωση παραστάσεων-συναυλιών (Broeske-Danielsen, 2013· Crawford, 2020· Dhillon & Ulmer, 2021· Howell, 2011· Hundertmark, 2019· Kenny, 2018· Marsh, 2012· Storsve et al., 2012· Migliarini, 2020· Millar & Warwick, 2019· Nicolaou et al., 2023· Rosen & Shoenberger, 2020).

Στις περισσότερες περιπτώσεις δεν γίνεται λεπτομερής περιγραφή του περιεχομένου των κοινοτικών παρεμβάσεων και προγραμμάτων ως προς το είδος και τον τρόπο οργάνωσης των δράσεων. Σε ορισμένες έρευνες γίνεται γενική αναφορά στο περιεχόμενο, όσον αφορά μουσικές ή κινητικές-χορευτικές δράσεις που προωθούν το διαπολιτισμικό διάλογο, τη δημιουργικότητα, τη συνεργατικότητα, την ανθεκτικότητα, τη συναισθηματική αποφόρτιση και τη γενικότερη ευζωία των συμμετεχόντων και τίποτα περισσότερο (Bleile et al., 2021· Crawford, 2020· Marsh, 2012).

Επιπρόσθετα, φαίνεται πως οι περισσότερες τονίζουν τις δυνατότητες των εκφραστικών και δημιουργικών δράσεων.

B. Ως προς τα οφέλη

Όπως διαπιστώνεται από την ανασκόπηση των ερευνών, τα προγράμματα μουσικής και χορού για ανήλικους πρόσφυγες φαίνεται να έχουν πολλαπλά οφέλη για την ευζωία των συμμετεχόντων. Στη συνέχεια παρουσιάζονται κατηγοριοποιημένα τα σημαντικότερα οφέλη που απαντήθηκαν στις επιλεγμένες έρευνες.

Κοινωνική συνοχή

Από τη μελέτη των προς ανασκόπηση ερευνών προκύπτει ότι οι τέχνες της μουσικής και του χορού μπορούν να ενδυναμώσουν την κοινωνική συνοχή και να ενισχύσουν τη συμπερίληψη και το αίσθημα του ανήκειν στην ομάδα (Crawford, 2020· Dhillon et al., 2020· Hundertmark, 2019· Kenny, 2018· Marsh, 2012· Marsh & Dieckmann, 2017· Millar & Warwick, 2019· Nicolaou et al., 2023· Rosen & Shoenberger, 2020· Storsve et al., 2010). Σε ορισμένες έρευνες γίνεται γενική αναφορά στη θετική συμβολή της μουσικής ως προς τη ενίσχυση των κοινωνικών σχέσεων και των συνδέσεων μεταξύ των συμμετεχόντων (Dhillon & Ulmer, 2021· Howell, 2011· Millar & Warwick, 2019).

Αυτό συνάδει με την άποψη πολλών άλλων ερευνητών, οι οποίοι υποστηρίζουν ότι η μουσική και ο χορός αποτελούν κατεξοχήν κοινωνικές τέχνες, καθώς ενισχύουν την κοινωνική συνοχή επιτρέποντας ποικίλες μορφές κοινωνικής δραστηριότητας (Αγαλιανού & Αρώνη, 2015· Murray & Lamont, 2012· Small, 1996· Στάμου και συν., 2023· Στάμου & Λίτος, 2024). Η θέση αυτή ενισχύεται από τον Thomas Turino (2008), ο οποίος μιλά για την έννοια του κοινωνικού συγχρονισμού (social synchrony), επισημαίνοντας ότι το συγχρονισμένο τραγούδι ή κίνηση καλλιεργεί την αίσθηση της σύνδεσης και ευνοεί την ανάπτυξη της αίσθησης του ανήκειν. Τέλος, ο Nigel Osborne (2009), διαπιστώνει ότι η δυνατότητα μουσικού και κινητικού συγχρονισμού οδηγεί στη συνειδητοποίηση της από κοινού πράξης και των κοινών σημείων ανάμεσα στα μέλη μιας ομάδας, ενώ επίσης γεννά «τον ενθουσιασμό, την ικανοποίηση, την ασφάλεια, τη συντροφικότητα και τη συνοχή του παιχνιδιού και της ρυθμικής κίνησης μαζί με τον άλλον» (σελ. 344).

Μη λεκτική επικοινωνία

Τα αποτελέσματα των ερευνών δείχνουν πως η μουσική και ο χορός μπορούν να αξιοποιηθούν σε εκπαιδευτικά πλαίσια με ανήλικους πρόσφυγες ως μέσα μη λεκτικής επικοινωνίας και σύνδεσης με τον «Άλλον». Υπερβαίνοντας τους λεκτικούς περιορισμούς, προωθούν την ουσιαστική αλληλεπίδραση και ενισχύουν τη δυνατότητα ανάπτυξης σχέσεων εμπιστοσύνης και φιλίας. Η ενσώματη εμπειρία, η καλλιτεχνική δημιουργία στην ομάδα, η μουσική και χορευτική επιτέλεση διευκολύνει την επικοινωνία μεταξύ ανθρώπων με διαφορετικό γλωσσικό, εθνικό και πολιτισμικό υπόβαθρο (Bleile et al., 2021· Crawford, 2020· Dhillon et al., 2020· Howell, 2011· Hundertmark, 2019· Marsh, 2012· Marsh & Dieckmann, 2017· Nicolaou et al., 2023· Rosen & Shoenberger, 2020· Storsve et al., 2010· Τρούλου και συν., 2024). Επιπλέον, οι Nicolaou et al. (2023) υπογραμμίζουν τη σημασία της παραστατικής διδασκαλίας των διαμεσολαβητών μέσω χειρονομιών, οι οποίες υποκαθιστούν τις λεκτικές οδηγίες και υποστηρίζουν τα εν λόγω περιβάλλοντα μάθησης.

Αυτά τα ευρήματα ενισχύουν απόψεις και άλλων μελετητών. Κατά την Hoffmann Davis (2010), η «γλώσσα» των τεχνών προσφέρει στους ανθρώπους ένα εναλλακτικό ρεπερτόριο έκφρασης. Σύμφωνα με τους Ακογιούνογλου και συν., (2016), η φωνή και η ρυθμική κίνηση του σώματος αναδεικνύονται ως εναλλακτικά μέσα έκφρασης για τα παιδιά πρόσφυγες, όπου δεν υπάρχει δυνατότητα για κοινή γλώσσα επικοινωνίας. Πολλοί ερευνητές υποστηρίζουν ότι ο χορός και η μουσική, ως τέχνες που βιώνονται μέσω των αισθήσεων, μπορούν να λειτουργήσουν ευεργετικά στην περίπτωση των προσφύγων, παρέχοντας ευκαιρίες για εσωτερική επεξεργασία και εξωτερίκευση των προσωπικών βιωμάτων μέσω της καλλιτεχνικής έκφρασης (Agalianou, 2021· Bareka et al., 2019· Davis, 2010· Dieterich-Hartwell & Koch, 2017).

Ασφαλές περιβάλλον

Σύμφωνα με τα συμπεράσματα των υπό ανασκόπηση ερευνών, οι παρεμβάσεις κοινοτικής μουσικής και χορού φαίνεται να δημιουργούν ευκαιρίες για την ανάπτυξη ατμόσφαιρας χαράς, αποδοχής, ασφάλειας και οικειότητας (Crawford, 2020· Dhillon et al., 2020· Dhillon & Ulmer, 2021· Hundertmark, 2019· Marsh & Dieckmann, 2017· Migliarini, 2020· Millar & Warwick, 2019· Nicolaou et al., 2023· Rosen & Shoenberger, 2020· Storsve et al., 2010). Πολλοί ερευνητές τονίζουν τη σημασία της απλής και κατανοητής δομής στις δραστηριότητες, καθώς και την αξιοποίηση μουσικοκινητικών και χορευτικών παιχνιδιών, διότι έτσι εξασφαλίζεται ένα προσιτό περιβάλλον καλλιτεχνικής έκφρασης που επιτρέπει την ασφαλή και με επιτυχία συμμετοχή όλων των μελών (Ακογιούνογλου, 2019· Ακογιούνογλου και συν., 2016· Marsh & Dieckmann, 2017). Επιπλέον, δραστηριότητες που βασίζονται στη μίμηση μουσικών ή χορευτικών μοτίβων παρέχουν ευκαιρίες συμμετοχής στο σύνολο των συμμετεχόντων, ενώ το τραγούδι σε ταυτοφωνία (unisono) και η από κοινού κίνηση φαίνεται να ενισχύουν την ενεργή συμμετοχή (Nicolaou et al., 2023). Μέσα από τη δυνατότητα για καλλιτεχνική έκφραση δύναται να αναπτυχθεί ένας ασφαλής χώρος για συναισθηματική αποφόρτιση (Ακογιούνογλου και συν., 2016· Στάμου και συν., 2023· Τρούλου και συν., 2024).

Ο Lee Higgins (2012) υπογραμμίζει ότι η συμμετοχή σε κοινοτικά προγράμματα γίνεται σε ατμόσφαιρα καλωσορίσματος, ενώ καθοριστικό ρόλο διαδραματίζει η φιλόξενη αλληλεπίδραση μεταξύ των μελών της ομάδας. Επιπρόσθετα, η Εύα Παυλίδου (2020) επισημαίνει πως η δημιουργία ενός υποστηρικτικού περιβάλλοντος αναδύεται από την άνευ όρων αποδοχή, αλλά και το περιεχόμενο των δράσεων (χωρίς οπτική επαφή, έκφραση μέσα από τον ήχο, ρυθμικός συντονισμός). Μέσα από τη μουσική και χορευτική πράξη, τα παιδιά μπορούν και οικειοποιούνται σταδιακά έναν άγνωστο ή και αφιλόξενο ως προς τις ανάγκες τους χώρο (Ακογιούνογλου, 2019), με αποτέλεσμα αυτός να μεταμορφώνεται από ένα απλό σημείο συνάντησης σε έναν νέο χώρο ασφάλειας, αποδοχής και αλλαγής (Higgins, 2012· Παυλίδου, 2020· Τρούλου και συν., 2024).

Διαπολιτισμικός διάλογος και αναδιαπραγμάτευση ταυτότητας

Σύμφωνα με τα ερευνητικά αποτελέσματα, η μουσική και ο χορός συνιστούν εν δυνάμει περιεχόμενα προγραμμάτων που εστιάζουν και ενισχύουν το διαπολιτισμικό διάλογο, την ομαλή διαδικασία επιπολιτισμού και ταυτόχρονα τη διατήρηση και προσαρμογή παραδοσιακών πολιτισμικών πρακτικών και ταυτοτήτων (Crawford, 2017· Crawford, 2020· Dhillon et al., 2020· Dhillon & Ulmer, 2021· Howell, 2011· Hundertmark, 2019· Kenny, 2018· Marsh, 2012· Marsh & Dieckmann, 2017· Millar & Warwick, 2019· Rosen & Shoenberger, 2020· Storsve et al., 2010). Σύμφωνα

με άλλους μελετητές, καλλιτεχνικά μέσα και μορφές μη λεκτικής επικοινωνίας παρέχουν στους πρόσφυγες δυνατότητες για αναστοχασμό και αναδιαμόρφωση της ατομικής και συλλογικής τους ταυτότητας, μέσα από την κατασκευή νέων νοημάτων και συνδέσεων που προσφέρει η ενσώματη εμπειρία (Agalianou, 2018· Dhillon et al., 2020· Dhillon & Ulmer, 2021· Singer et al., 2016). Ο Lee Higgins (2012) επισημαίνει ότι οι καλλιτεχνικές κοινοτικές παρεμβάσεις βρίσκονται στον αντίποδα πρακτικών εξομοίωσης και απόκτησης κοινής ταυτότητας και μπορούν να λειτουργήσουν ευεργετικά για την προσωπική και κοινωνική μεταμόρφωση, μέσα από την ανάδειξη και αποδοχή της διαφορετικότητας.

Διαμόρφωση και ενδυνάμωση της άποψης

Ο Higgins (2012) υποστηρίζει πως η αίσθηση ασφάλειας και ισότητας μεταξύ των μελών μιας ομάδας προκύπτει μέσα από τη δυνατότητα για έκφραση όλων των «φωνών» και τη διϋποκειμενική εμπειρία, κατά την οποία ο κάθε συμμετέχων «μοιράζεται τον κόσμο του ως δώρο» (σ. 165). Η θετική αυτή επίδραση σημειώνεται και σε ορισμένες υπό μελέτη έρευνες (Dhillon et al., 2020· Dhillon & Ulmer, 2021· Migliarini, 2020). Τα εργαστήρια μουσικής και χορού hip-hop (Migliarini, 2020), καθώς και η ενεργοποίηση του σώματος μέσω της δημιουργικής κίνησης (Dhillon et al., 2020· Dhillon & Ulmer, 2021) μπορούν να λειτουργήσουν θετικά ως προς την ισχυροποίηση της «φωνής» των προσφύγων. Η δημιουργική κίνηση και η οπτική βιογραφία μπορούν να δώσουν «φωνή» και να ενδυναμώσουν τα περιθωριοποιημένα σώματα, επιτρέποντας στους νέους να αναγνωρίσουν και να επανακαθορίσουν τη σωματική τους ταυτότητα και αξία μέσα στην κοινότητα (Dhillon & Ulmer, 2021). Μέσα από τη μη λεκτική καλλιτεχνική έκφραση, οι συμμετέχοντες έχουν τη δυνατότητα να προβάλλουν την προσωπική οπτική και να ακουστούν στο πλαίσιο της ομάδας (Ακογιούνου, 2019). Η διαδικασία αυτή διευκολύνεται, όταν το επίπεδο της μουσικής δυσκολίας επιτρέπει την ενεργή συμμετοχή όλων των συμμετεχόντων (Austin, 2002 στο Ακογιούνου, 2019).

Αίσθηση ελέγχου και αυτοπεποίθηση

Η ζωή των προσφύγων χαρακτηρίζεται από αστάθεια και παροδικότητα στο παρόν και το μέλλον, ενώ οι επίπονες εμπειρίες του παρελθόντος έχουν ως αποτέλεσμα οι πρόσφυγες να αισθάνονται αβοήθητοι και μετέωροι (Agalianou, 2021). Τα παιδιά και έφηβοι πρόσφυγες φέρουν την αίσθηση απώλειας ελέγχου της ίδιας τους της ζωής, καθώς αδυνατούν να πάρουν αποφάσεις καθοριστικές για τις βιοτικές τους συνθήκες (Agalianou, 2021· Ghandour, 2001). Η ανασκόπηση των ερευνών δείχνει ότι τα μουσικά και χορευτικά εργαστήρια με ανήλικους πρόσφυγες συμβάλλουν στην ανάπτυξη της ικανότητας αυτενέργειας, της αίσθησης του ελέγχου (Kenny, 2018· Millar & Warwick, 2019· Storsve et al., 2010), καθώς και της αυτοπεποίθησης (Dhillon et al., 2020· Howell, 2011· Hundertmark, 2019· Marsh & Dieckmann, 2017· Millar & Warwick, 2019· Storsve et al., 2012).

Αυτό συμβαίνει μέσα από ευκαιρίες για μουσικές επιλογές και ηγετικούς ρόλους που οι συμμετέχοντες αναλαμβάνουν κατά τη διάρκεια μουσικών δραστηριοτήτων (Kenny, 2018). Σε αυτή την κατεύθυνση, η Ολυμπία Αγαλιανού (2021) συμπληρώνει πως η αίσθηση του ελέγχου προσεγγίζεται μέσα από τη δημιουργική διαδικασία, η οποία βασίζεται σε απλά μουσικοκινητικά μοτίβα και τρόπους σύνδεσης. Καθώς τα παιδιά λαμβάνουν απλές μουσικές αποφάσεις, συνειδητοποιούν άμεσα τον αντίκτυπο αυτής της επιλογής μέσω των αισθήσεων και επανακτούν σταδιακά την ικανότητα λήψης αποφάσεων, ανταλλαγής και εξέλιξης μιας ιδέας (Agalianou, 2021).

Κίνητρα για μάθηση και σύνδεση σχολείου-κοινότητας

Ορισμένες υπό μελέτη έρευνες υποστηρίζουν ότι η μουσική και ο χορός μπορούν να συμβάλλουν στην ενεργή συμμετοχή των ανήλικων προσφύγων σε μαθησιακές διαδικασίες (Crawford, 2020· Millar & Warwick, 2019· Nicolaou et al., 2023· Rosen & Shoenberger, 2020· Storsve et al., 2010) ή/και να αποτελέσουν γέφυρα σύνδεσης ανάμεσα στο σχολικό και το κοινοτικό περιβάλλον (Dhillon et al., 2020· Dhillon & Ulmer, 2021). Οι Millar και Warwick (2019) επισημαίνουν ότι η μέθοδος της αλληλομάθειας μπορεί να ενισχύσει τη μαθησιακή διαδικασία, καθώς οι δεξιότητες αναπτύσσονται μέσω της αλληλεπίδρασης, με τους μαθητές να εμπλέκονται ενεργά χωρίς να συνειδητοποιούν ότι μαθαίνουν. Οι Dhillon και Ulmer (2021) επεκτείνουν αυτή την ιδέα, υπογραμμίζοντας ότι τα μοτίβα κίνησης προάγουν τον φυσικό γραμματισμό και σε συνδυασμό με την οπτική βιογραφία, επιτρέπουν στους νέους να δημιουργούν το δικό τους προσωπικό πρόγραμμα μάθησης, εκφράζοντας την αυθεντική τους ταυτότητα.

Επιπλέον, η ενασχόληση με τη μουσική μπορεί να ενισχύσει το αίσθημα προσωπικής ικανότητας και να καλλιεργήσει αισιοδοξία για το μέλλον, συμβάλλοντας ουσιαστικά στην ανάπτυξη των εκπαιδευτικών δυνατοτήτων των νέων προσφύγων (Millar & Warwick, 2019). Ειδικότερα, η ευχαρίστηση και η διαπροσωπική σύνδεση που απορρέει από τις μουσικές και κινητικές δραστηριότητες φαίνεται να προωθεί τη δημιουργία κινήτρων για μάθηση και να συνδέεται με τη συστηματικότερη σχολική φοίτηση των μαθητών προσφύγων (Crawford, 2017· 2020· Millar & Warwick, 2019· Nicolaou et al., 2023). Η βαθύτερη κατανόηση της γλώσσας μέσα από το τραγούδι συνεισφέρει στη συνολική ακαδημαϊκή απόδοση των προσφύγων μαθητών και στη διαμόρφωση θετικής στάσης απέναντι στο θεσμό του σχολείου (Crawford, 2017· 2020), ενώ η κατανόηση της ομιλούμενης γλώσσας συνδέεται άμεσα με την ενεργότερη συμμετοχή στην εκπαιδευτική διαδικασία (Howell, 2011). Παράλληλα, οι Rosen και Shoenberger (2020) τονίζουν ότι η έκθεση των μαθητών σε νέα μουσικά ακούσματα μπορεί να ενισχύσει την περιέργεια και την επιθυμία τους για περαιτέρω ενασχόληση με τη μουσική.

ΚΑΤΑΚΛΕΙΔΑ

Παρά τη διαπίστωση πως πραγματοποιούνται όλο και περισσότερα προγράμματα που αξιοποιούν τις κοινοτικές τέχνες, δεν φαίνεται να έχουν διερευνηθεί επαρκώς τα αποτελέσματά τους. Επιπρόσθετα, οι έρευνες που περιλαμβάνουν κοινοτική παρέμβαση με μουσικό και χορευτικό-κινητικό περιεχόμενο φαίνεται να είναι περιορισμένες και λιγότερες από εκείνες που η κατεύθυνση των παρεμβάσεων αφορά το πεδίο της θεραπείας μέσω των τεχνών. Διαπιστώνεται, επίσης, έλλειψη μελετών που διερευνούν εστιασμένα την επίδραση του χορού σε κοινοτικά πλαίσια ή μελετούν τις επιδράσεις του συγκριτικά με αμιγώς μουσικές ή συνδυαστικές (μουσικοχορευτικές) παρεμβάσεις. Ο χορός σπάνια αξιοποιείται ως κύρια μορφή τέχνης σε κοινοτικά προγράμματα, ενώ πιο συχνά απαντάται ως συμπληρωματικό συστατικό στις εκδηλώσεις προς το ευρύτερο κοινό (Poynor & Simmonds, 1997) ή συνδυαστικά με μουσικά ή άλλα καλλιτεχνικά κοινοτικά προγράμματα. Αναφορικά με το περιεχόμενο των προγραμμάτων που μελετώνται στο πλαίσιο των ερευνών της παρούσας βιβλιογραφικής ανασκόπησης, επιβεβαιώνεται η ποικιλία ως προς το είδος δραστηριοτήτων και είδος μουσικής ή χορού που αξιοποιείται στο πλαίσιο τους,

ενώ σε αρκετές περιπτώσεις εντοπίζεται μόνο γενική περιγραφή του περιεχομένου με βάση τη στοχοθεσία της κάθε μελέτης.

Μια άλλη παρατήρηση αφορά στις μεθόδους που χρησιμοποιούν οι έρευνες. Είναι φανερό η σχεδόν απόλυτη επικράτηση μελετών ποιοτικού χαρακτήρα και η απουσία ερευνών ποσοτικού ή μεικτού χαρακτήρα, που θα μπορούσαν να προσφέρουν περαιτέρω υποστήριξη στα έως τώρα ευρήματα. Διαπιστώνεται, επίσης, ότι η πλειοψηφία των ερευνών εστιάζουν σε προγράμματα και παρεμβάσεις μικρής διάρκειας και ότι το δείγμα συμμετεχόντων είναι μικρό. Σπάνια δε απευθύνονται σε ανήλικους και ειδικότερα σε παιδιά πρόσφυγες. Αυτές οι διαπιστώσεις και κυρίως οι ερευνητικοί περιορισμοί, σε συνδυασμό με τον μικρό αριθμό των εντοπισμένων ερευνών, έχει αντίκτυπο στη σημαντικότητα των αποτελεσμάτων της παρούσας έρευνας. Πρόκειται, λοιπόν, για ενδεικτικά αποτελέσματα, τα οποία βασίζονται μόνο σε 15 έρευνες στις οποίες εντοπίζονται ερευνητικοί περιορισμοί.

Χρειάζεται, λοιπόν, η διενέργεια περισσότερων μελετών, οι οποίες να αφορούν παρεμβάσεις μεγαλύτερης διάρκειας και να μελετούν μεγαλύτερα δείγματα. Ιδιαίτερη βαρύτητα πρέπει να δοθεί και στον ερευνητικό σχεδιασμό. Η αναλυτική παρουσίαση της μεθοδολογίας, η επιμέλεια θεμάτων αξιοπιστίας και εγκυρότητας εργαλείων και μεθόδων, καθώς και ποσοτικού χαρακτήρα μετρήσεις σε συνδυασμό με ποιοτικές προσεγγίσεις φαίνεται να είναι απαραίτητες. Με αυτόν τον τρόπο, θα επιτευχθεί μια εκτενέστερη και βαθύτερη μελέτη των επιδράσεων μουσικής και χορού σε κοινοτικά προγράμματα για ανήλικους πρόσφυγες και σε μεγαλύτερη γενίκευση των σχετικών ευρημάτων. Επιπλέον, θα προκύψουν περισσότερα ευρήματα ικανά να συμβουλευσουν την οργάνωση και λειτουργία τέτοιων προγραμμάτων, γεφυρώνοντας έτσι την έρευνα με την πράξη και προάγοντας το πεδίο των κοινοτικών προγραμμάτων για ανήλικους πρόσφυγες. Θα ήταν επίσης βοηθητικό η έρευνα να ασχοληθεί και με το προφίλ διαμεσολαβητών τέτοιων παρεμβάσεων (Στάμου και συν., 2023).

Επίσης, θα ήταν πολύ χρήσιμο η κάθε μελέτη να συνδέεται με την γενικότερη πολιτική και κοινωνική κατάσταση της χώρας στην οποία διενεργείται ή την διενεργεί. Βέβαια, η αντιμετώπιση του προσφυγικού ζητήματος σε επίπεδο πολιτικής, αφενός ποικίλει από χώρα σε χώρα, αφετέρου είναι δυναμική και για αυτό υπόκειται σε συνεχείς αλλαγές, μικρότερες ή μεγαλύτερες. Ο σχεδιασμός παρεμβάσεων, η διερεύνησή τους και η αποτίμηση των αποτελεσμάτων συνδέεται με το πολιτικό, κοινωνικό και πολιτισμικό εκάστοτε πλαίσιο. Στην περίπτωση της παρούσας ανασκόπησης δεν θα ήταν δυνατό να επιχειρηθεί μια τέτοια σύνδεση για κάθε έρευνα ξεχωριστά, δεδομένης της γεωγραφικής διασποράς των ερευνών και αυτό αποτελεί έναν περιορισμό. Σύμφωνα με τα παραπάνω, αναδύεται η ανάγκη για εκτενέστερη σχετική έρευνα με στόχο τη βαθύτερη κατανόηση του τρόπου παιδαγωγικής και καλλιτεχνικής λειτουργίας των κοινοτικών προγραμμάτων μουσικής ή/και χορού και τη συνεισφορά στον προβληματισμό και την επιστημονική συζήτηση.

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English abstract | Αγγλική περίληψη

Community music and/or dance programmes and interventions for refugee minors: A literature review

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ABSTRACT

The recognition of the arts' role in enhancing social well-being has led to the development of art-based practices that target vulnerable social groups. Today, community arts constitute a distinct field of artistic practice and scientific research that aims to manage social problems and strengthen social cohesion. The refugee issue is timeless and particularly topical in recent years. Refugee children face many difficulties during their acculturation process, such as access to public goods and services, destabilization, emotional challenges, identity issues, social discrimination, and marginalisation. The present research aims to study music and dance practices that are used in programmes aimed at refugee minors in terms of their content and effectiveness. A descriptive review of research on community music and/or dance programmes targeting to refugee minors was conducted to achieve this aim. According to the results, the content diversity is extensive, focusing on music, while dance seems to be used mainly as a complementary activity in community music programmes. It is important that regardless of the programmes' content, music and dance emerge as valuable tools for personal development and communication. At the same time, they can contribute to social cohesion and the enhancement of intercultural dialogue.

KEYWORDS

community music, community dance, community programmes, community interventions, refugee minors

ARTICLE

Trusting the uncertainty: Music therapy with young people who have experienced attachment trauma

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ABSTRACT

Psychological trauma has recently received increased attention in music therapy, resulting in a dramatic increase in writings about this subject. However, the voice of clinicians and participants is not represented strongly in the literature. This paper is an attempt to begin to fill in this gap, providing examples from practice presented through narratives that illustrate music therapist's perspective on the work, the clients' expressions, and relationships. Following case vignettes taken from music therapy sessions, reflections on the work are integrated with relevant literature. The vignettes capture moments where key concepts of trauma-informed practice, such as trust and safety, are being challenged and questioned. They serve as a starting point for connecting theoretical knowledge with lived experiences and are intended to bring awareness to the reader in a way that is intuitive and emotional, as well as intellectual.

KEYWORDS

attachment trauma,
trauma-informed
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INTRODUCTION

A growing body of literature and research is available on psychological trauma and posttraumatic stress and its consequences. This includes neurobiological (Akiki et al., 2018; McCrory et al., 2011; Opendak & Sullivan, 2019; Packard et al., 2021; Perry, 2009; Stark et al., 2015), psychobiological (Fuchshuber et al., 2019; Lahousen et al., 2019), and clinical/therapeutic approaches (Allen, 2013a; Baylin & Hughes, 2016), as well as resources that integrate these perspectives (Rotschild, 2000; Schore, 2010; van der Kolk, 2015). There are different ways of understanding trauma. Some

resources, including the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013) focus on the traumatic events that define trauma, stating that the trauma requires “actual or threatened death, serious injury, or sexual violence” (p. 271). This criterion is therefore quite objective. The 4th edition of the DSM (4th ed.; DSM-4, American Psychiatric Association, 1994) also included the subjective criterion of personal response to the event (fear, horror, and helplessness), but that was removed from the current version; this remains a subject of professional debate (Pai et al., 2017). Other resources conceptualise trauma as a single or repeated threatening experience that leaves the person powerless, in emotional shock (Farina et al., 2019; Reyes et al., 2008), thus including both objective and subjective components. Finally, some authorities understand trauma not as a specific event (or events), but as stress or even an emotional response alone (Krupnik, 2020).

Available materials include varying perspectives that bring a great deal of information, which sometimes form a coherent whole but at other times suggest contradictory ideas. Neurobiological, psychological, and clinical readings provide fundamental knowledge for clinicians working with people who experienced psychological trauma and allow for improved understanding of the functioning of the clients (Cristobal et al., 2017; Dorrington et al., 2019; Scoglio et al., 2022). At the same time, however, due to the wide spectrum of issues related to this area, the vastness of the resources might lead the reader to a feeling of helplessness. Even in terms of terminology, different words are used. Although they may have slightly different meanings, they are frequently used to discuss the same or similar issues. Terms range from general, such as “psychological trauma” (Hogg et al., 2022), to more specific. They may focus on different aspects of the experience, such as developmental trauma (Cruz et al., 2022), childhood trauma (Vanderzee et al., 2018), relational trauma (Alexander, 2013), childhood maltreatment (Kim et al., 2022), or attachment trauma (Allen, 2013b).

Psychological trauma is receiving increased attention in music therapy and, as in other disciplines, uses a variety of terms and concepts. McFerran et al. (2020) conducted an interpretive synthesis with 36 studies: they identified clinical music methods used with people who experience different kinds of psychological trauma and assessed whether the theoretical and research bases were provided as justification for the work. Included studies were identified by searching “music” or different ways of utilising music (songwriting, drumming, songs, Guided Imagery and Music) and “trauma” or “Post-traumatic stress disorder” (PTSD), “abuse,” and “foster care.” Through this analysis, McFerran et al. constructed framework of different ways of using music with people who have had adverse life experiences. These were found to be for stabilising, entraining, expressing, and performing purposes. However, a limitation of the findings was that different trauma-related groups were considered together, including various types of acute and chronic traumas. A growing body of studies regarding different kinds of psychological trauma and music therapy have been done. These include different types of work with children, young people and families (Bolger, 2015; Choi, 2010; Christenbury, 2017; Faulkner, 2017; Felsenstein, 2013; Osborne, 2012; Strehlow, 2009; Wiess & Bensimon, 2020; Zanders, 2015), and adults (Beck et al., 2018; Bensimon et al., 2017; Rudstam et al., 2017).

In two qualitative studies, Bensimon (2020, 2022) used grounded theory and phenomenological approaches to explore the techniques that music therapists apply while working on relational needs

of people who have experienced trauma (2020) and when facilitating integration in trauma survivors (2022). Relational needs of the clients were identified as the need for recognition, acceptance, emotional witnessing, emotional responsiveness, safety, trust, and for someone to reach out to them. Regarding how the treatment of trauma was focused on integration, Bensimon (2022) constructed three categories that illustrate the levels at which music therapists work: body integration, event integration, and life story integration. His studies provide insights into clinical processes and music therapists' perspectives.

Several books (Beer & Birnbaum, 2022; Gravestock, 2021; Sutton, 2002) on trauma also focus on clinical work from music therapists' perspectives. Gravestock (2021) elaborates on the lived experiences of music therapy in adoption and trauma. Her publication contains vignettes describing people and situations that occur in this work. Beer and Birnbaum's book (2022) provides theoretical considerations regarding concepts such as resilience and cultural humility, and reflections on different areas of practice in which trauma is present, including adverse childhood events, race-based traumatic stress, natural disasters, cancer care, sexual violence, mental health, and in the Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual (LGBTQAI+) community.

Trauma-informed clinical guidelines and principles for music therapists have recently been published (Heiderscheit & Murphy, 2021). They are based on a general trauma-informed practice approach and focus on key principles formulated by Substance Abuse and Mental Health Services Administration (SAMHSA, 2014), including safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment (for staff and clients), voice and choice, cultural, historical, and gender issues. These aspects were conceptualised within a resilience framework, which provides a perspective on the therapeutic process (Sokira et al., 2022). Three important stages that were identified were establishing safety, remembrance and mourning, and reconnection.

Critical reflections regarding trauma-informed work in the field of music therapy are also available. Although the above-mentioned materials cover clinical aspects of music therapy work, it was noted in the recent scoping review regarding music therapy and adverse childhood experiences (Abrahams et al., 2023) that clear overview of the interventions in this area is difficult to perform. It is due to the fact that the existing materials are inconsistent with regards to the terminology used in the descriptions of interventions and goals.

Potentially controversial perspectives that challenge the dominant narrative of trauma-informed work were proposed by Scrine (2021), Scrine and Koike (2022), and Hillman et al. (2022). After analysing and interpreting available music therapy literature, Scrine (2021) concluded that the "dominant trauma paradigm has the potential to further perpetuate harm, and does so through assigning vulnerability, reinscribing colonial power dynamics, and reinforcing individual responsibility" (Conclusion, par. 1). Scrine (2021) also suggested that this paradigm can be challenged by music therapists by fostering resistance and collective consciousness-building with young people. Scrine and Koike (2022) reflected on the idea of safety and proposed to reconceptualise it as a complex, ongoing relational practice. Hillman et al. (2022) critically examined assumptions supporting research regarding music therapy and psychological trauma with adult populations. They found that the participant's voice was lacking in the current literature, with clinical discourse and psychiatric constructions of trauma recovery being represented the most.

THE CURRENT PAPER

Aims and structure

This reflective paper has two main aims. The first aim of this paper is to present my own voice as a clinician, and – indirectly – the clients' voices, within the case vignettes and the interpretations that follow. This aim comes from considering Hillman et al. (2022) and Scrine and Koike's (2022) points regarding the need for including participant's voices in the discourse. Participants of the music therapy process are understood here as both the music therapist and the clients. Also, this aim is derived from a key principle of SAMHSA (2014), of which empowerment for staff and clinicians are treated as a base. In this case, the staff will be represented by myself, a music therapist. The clients will be introduced in the narratives.

I will try to capture lived experiences of being in a music therapy process with young people who experienced attachment trauma, but attempt to avoid a traditional, hierarchical clinical discourse perspective and psychiatric constructions. I am aware that the line between clients' voices and my interpretation is unclear and blurry. However, in music therapy practice, these two elements seem to be intertwined and sometimes even inseparable. Therefore, in the vignettes below I will use direct verbal quotations from the conversations, together with my interpretations and observations from the sessions.

The second aim is to integrate chosen literature with everyday experiences of the music therapist. Translating and transferring knowledge from theory and research to the practice can be a challenge in this area. Nevertheless, combining research and clinical experience together with patients' unique experiences is the core of evidence-based practice (Straus et al., 2019). In this article, I hope to link selected research and knowledge on attachment trauma and music therapy with my clinical experience. I will present the vignettes, followed by relating them to the selected readings.

While psychological trauma is a broad and ambiguous term, the other terms mentioned before identify more concrete conditions. In the current paper, clients' ages, levels of development, or adverse events experienced are not central to what is reported. "Attachment trauma" will be used, as it seems to describe the clients' difficulties most accurately. It will be understood according to Allen's (2013b) conceptualisation, which relate to trauma that took place within attachment relationships and manifests through profound mistrust. This type of trauma is associated with childhood neglect and abuse. I believe that a naturalistic perspective and personal insights are important and that the language should reflect these aspects. Therefore, the vignettes will be presented in the forms that come from everyday expressions, even colloquialisms, rather than in an academic style of writing.

I consider these means of presenting the information worthwhile for at least three reasons. It will:

- 1) Allow for including the words of the clients in the original form, initially without interpretation;
- 2) Promote connecting theoretical and research knowledge with lived experiences; and
- 3) Inform and bring awareness to potential readers, including clinicians who might struggle

with similar situations, in a way that is intuitive and emotional rather than purely intellectual. The sense of something being revealed does not always easily translate to words, but it can be grasped intuitively, in the emotional realm. I hope to convey this sense to others through the style of the vignettes.

The context and the participants

All of the vignettes below are based on experiences I had during music therapy work in a foster care institution in Poland. The young people whose stories are shared were abused physically, psychologically, and/or sexually before they entered the institution, and sometimes also afterwards. They all meet the criteria of trauma understood as an event. Attachment trauma is implied, considering the history of their family relationships. They live in an environment that puts them at risk of re-traumatisation and does not always support resilience; child maltreatment in foster care settings is common and known to have negative effects on their adult mental health (Lueger-Schuster et al., 2018). The parents' rights of these young people are limited.

There are many studies reporting associations between childhood maltreatment and alterations in brain, regarding its structure, function, connectivity, and network architecture (Tomoda et al., 2024). These alterations can be observed in behaviours. Young people might struggle with many symptoms related to attachment trauma/developmental trauma disorder: emotion dysregulation, somatic dysregulation, hyper- or hypo-vigilance, reactive aggression, impaired psychological boundaries, and difficulties in building relationships and feeling close to others (van der Kolk et al., 2019). The clinical work was done with respect to van der Kolk (2003) suggesting that children who experienced trauma “must learn to know what they feel, put those feelings into words, or find some other symbolic expression (drawing, play acting) that can allow them to gain distance from the traumatic events and help them imagine alternative outcomes” (p. 310).

Ethical considerations

The vignettes that are presented below describe moments of music therapy from recent work. The young people who are portrayed provided written consent to share these vignettes in anonymised versions. The consent was designed to be user-friendly and understandable. Young people also had a chance to ask questions and discuss the content and its extent with me, as a music therapist and author.

Obtaining the consent was done retrospectively, following the therapy but before completing the paper. Consent was also obtained from the foster care institution. The Ethics Board of the academic institution was also consulted concerning content of the paper and how it was presented.

CASE VIGNETTES AND REFLECTIONS

Case vignette 1 – Peter's song. On trust

Peter is 16 years old, bright and very sensitive. He has never met his father, but from what his mother says, his father was addicted to alcohol and used to abuse the family physically. Peter has two older

brothers. One of them, David, having received a good education, is doing very well, has a well-paying job, and is in a stable relationship.

Peter is shy during music therapy. He is reluctant to improvise. He wants to learn how to play guitar. He strums basic chords with lots of hesitation. When I suggest writing a song, he seems to like the idea, but postpones it until the next session. When it comes, he brings the lyrics, almost complete, written on a piece of paper. They are deep, poetic, full of metaphors, with rhymes, and an interesting structure. Wonderful! He says he also had an idea for melody but angrily claims he forgot it. I try to facilitate recalling or just recreating the music, but whatever I do, Peter is not satisfied.

After the session, I find myself quite surprised. I have doubts as to whether the lyrics were written by the client himself. I Google the words, but nothing appears; he did not find them on the internet.

Peter brings his smartphone to the next session, with a voice recording of his brother, David, singing the song – the lyrics and melody – with intense personal involvement. According to Peter, he explained to the brother what the melody was supposed to be, “and he got it much better than me before,” so they recorded it for the session. Peter is very tense, and there is some kind of new awkwardness during the part of the session based on the song. We work on the song for few more weeks, and then I suggest writing another song during the session. So we go through the process together, and it is fun. However, it becomes obvious that Peter would not have been able to write the words of the first song by himself. I start to think that the previous piece was composed by the brother, but do not confront Peter with this suspicion.

The weeks go by with an accelerated therapeutic process based on songwriting. New songs are written during the sessions, the relationship seems more and more stable and safe, there is high energy and spontaneous fun.

A few months later, before leaving the session room, Peter says: “I have one thing to say... I guess you know... or maybe not... but probably so... I did not write our first song.” “Yeah? But so what?”, I answer. “So nothing”, Peter laughs, relieved, and leaves the session.

Much later, with therapy having ended four years earlier, and living a successful, independent adult life, Peter meets me and says: “Music therapy made a huge change for me. Do you know what was the best part of our meetings? That you trusted me despite my lies.”

Case vignette 2 - Vera's stories. On trust again

Vera is 10. She is doing great: no problems at school, good friends, and lots of interests. She wants to be a teacher. She has been in the institution since she was 4 years old. Because her parents were and are imprisoned, she lived with her grandmother prior to coming to the foster home. She likes music, plays instruments freely, sings songs loudly. Her favourite part of music therapy is musical story telling. From time to time, she comes to the room and says: “Let's do the story. I will tell you the story, and you will play. It is a real memory of mine from the times I lived with Grandma.”

So that is what we do. She usually starts by making sure that I know exactly where she lived. Her grandmother's house with the full address, the real one. She describes the area in detail. She asks if I know this part of town. I do, her description fits the reality perfectly.

One day, it was sunny and warm, I decided to go to the park close to the house. I went there and, you know, it is more of a forest. I went there, further and further. Do you know this park?

'Yes I do', I say, while accompanying her story with guitar. I truly do, I know the park. She continues:

I was there for a long time, and it started to get dark. And suddenly.... [dramatic pause] the huge wolf jumped out from the trees, and started to run after me. Can you believe it? I was so scared, I ran so fast, the wolf was huge, and black, with white teeth, running so so fast. Do you believe me? I managed to escape. But I was soooo terrified.

Sometimes it is a wolf, sometimes a bear, sometimes both, or a ghost, or a dragon, or some other horrible creature. But always, in between every few sentences, she asks if I believe her. When the story is done and the music is over, she asks again, do I trust her?

There are no wild creatures in our city. She knows it and I know it. But for some reason it feels important for her to hear: Yes, I do believe you. I am so sorry it happened. I can only imagine how scary it was.

A reflection on trust in music therapy with young people who experienced attachment trauma

Although quite different, both vignettes have one common denominator: they question trust and its relation to deception within the therapeutic process. One can read that trust is one of the most important factors in the therapy of people who experienced trauma. "Trust is the basis of healthy and helpful therapeutic relationships. Individuals who have experienced interpersonal trauma, including adverse childhood events, are more likely to have trouble trusting others" (Heiderscheit & Murphy, 2021, p. 2). And to be trusted by others, one could add. As Peter and Vera show, trusting someone is difficult, but being trusted – hard to believe. Trust should go both ways.

Working with Peter and Vera supports the importance of trust, but brings nuances and shades of meaning to this notion. It occurs to be very much context- and individual-dependent. Trust can manifest in myriads of ways in therapeutic relationships, and it needs to be treated carefully and flexibly.

Profound mistrust, which is core to attachment trauma, causes young people to choose paths of development and relationship building in ways that may be surprising and sometimes paradoxical. It causes the therapeutic process to be indirect and involves a high level of uncertainty. There is the possibility of misunderstandings and misinterpretations, alongside the risk of making wrong decisions. From my perspective, it is not possible to overcome it by finding a common rule that would apply or following universal guidelines, which are by nature depersonalised and general.

It was found that "a high percentage of clients (93%) reported lying, in one fashion or another, to their therapist and that, for the most part, this occurs across all types of clients across all types of psychotherapies" (Blanchard & Farber, 2016, p. 106). At the same time, the experience of being lied to has a deteriorating impact on trust (Gawn & Innes, 2017). When working with young people who experienced attachment issues, one should be aware that "it is not uncommon for children with a history of maltreatment to exhibit symptoms of aggression, defiance, stealing, lying ... all of which

may be driven by stored, unprocessed traumatic memories” (Shapiro et al., 2017, p. 287). Therefore, it seems important to define what lying is and how to deal with it in a therapeutic relationship, with trust in mind.

In general, lying is simply a form of dishonesty, such as when someone intentionally communicates in a misleading way in order to achieve some kind of goal. However, going deeper into the subject, it becomes clear that lies have very different features. They may be protective or beneficial, serving the lying person or others, being connected to self-regulation and social norms (Cantarero et al., 2018).

There is also pathological lying. It can be a symptom of PTSD or the result of childhood trauma or neglect. It might stem from low self-esteem. This behaviour is neurobiologically linked to dysfunction in the prefrontal cortex and limbic system, which are involved in executive functioning, impulse control, and emotional regulation (Kainth & Gunturu, 2024).

So how should we think about lies in the situations mentioned? Are they pathological? How should we treat them as we try to build trust? Baylin and Hughes (2016) suggest that maltreated children might construct their own reality, hoping to get the attention and safety that are not possible in the real world. If that is the case, being invited to the constructed reality and accepting it may actually lead to getting closer, not being manipulated. For maltreated children, using lies might also be a coping mechanism and a strategy to build safety. From the neurobiological perspective some research (Rubinestein & Lahad, 2023) suggests, that the hippocampus and the default mode network play an important role in both creativity and PTSD. Creativity and playfulness are also perceived as significant predictors of resilience after traumatic experience.

Another question, what do we want to trust as therapists? Which truth are we searching for? The factual one? The subjective one? The emotional one? Maybe when Peter presented his brother’s song as his own, he wanted to be seen as more able, so presenting the song was the act of offering the truth about his ideal self, the self he is trying to achieve. When Vera was telling her story, she was communicating very honestly about her emotional memories from the past, the terror she felt, even though the wild creatures were not the reason for this feeling. During the initial stage of work, the therapist’s main task is “to establish trust and foster engagement in the music. Focus should be on providing experiences that allow the client to safely explore, experience, and connect with self and others through music while providing a sense of control” (Sokira et al., 2022, pp. 12-13). The vignettes above support these words, but at the same time show that the understanding of trust should not be treated rigidly and although in certain situations lies erode trust, in the context of a therapeutic process with a person with attachment trauma, lies might be tools to build trust and communicate deeper truth. Acknowledging these personal narratives and staying indifferent or accepting towards them can be beneficial for the therapeutic process.

Case vignette 3 – Maja’s concert performance. On safety

Maja’s mother is almost 30, and Maja is 11 years old. They like each other. They both have Facebook accounts. One day, mother posts a photo of herself and a photo of Maja with a question: Which one is prettier? Give likes for Maja and hearts for me. Both received a lot of reactions; the comments

were full of funny emojis.

Maja loves music and enjoys music therapy a lot. As she has been at the facility since she was five, she has had many good experiences with improvising, singing, and playing. She likes to perform and took part in many concerts, finding being on stage stressful but exciting.

Another concert is planned in the near future, this time in a fairly large concert hall at the local Academy of Music, with music therapy students participating. Maja chooses a song to be performed that had been presented just a week earlier on *Idol* or some other television show and received a huge emotional reaction. The song was written by a young man whose mother had passed away some time ago. The lyrics are in the form of a letter to the mom, expressing lots of pain. The music is delicate and intimate, the voice is accompanied only by the piano; it could easily be categorised as kitsch. I am not very fond of this choice, it is too emotional and direct, plus it triggers my emotions and makes me cry. But Maja is sure about her choice, and she seems untouched by the song's verbal content or musical character. During sessions, she is relaxed, funny, and giggly. She sings this song the same way she did previous songs, very musically, commenting on 'technical' aspects such as whether she is able to memorise it all, when to start, how long is the instrumental interlude between the verses, and so forth. One of the music therapy students offers to accompany her on the piano. She comes for rehearsals and establishes a friendly atmosphere; clearly Maja feels comfortable with her. Maja chews gum, moves to the music, looks completely chilled.

The day of the concert arrives. Maja wears a nice dress. There is tension in the group of performers, but it is perfectly natural as the audience is large. Maja's mother comes and the daughter has her sit in the first row.

It is Maja's turn. She goes on stage and sits at the piano bench with the music therapy student. She planned the performance this way. The spotlight is on them only. She starts singing and you can hear more and more emotion in her voice. It is trembling. Maja is short of breath. In the middle of the song, she stands up. She takes her mic and slowly starts to walk to the edge of the stage where the mother sits.

The lyrics are:

I want you to read this letter that was being written for many nights.
You gave me everything, I can see the sky thanks to you.
Thanks to you I can live, I can dream, I can love and forgive,
So I forgive you, that you are not here today.
Mom, I miss you most of all.

Her voice weakens and finally she stops singing and starts crying, fighting her tears for a moment and then losing it all together, crying openly in the centre of the stage. People applaud. Maja sits on the lap of a caregiver from the institution, hides her face in her arms. Mother sits just a few chairs away.

The next day Maja says to me: "See, I was right to choose this song. I made such a show! Exactly as I wanted. I surprised you! I even made some people cry. Did you see my Mom crying?! I am so relieved now."

She seems happy, a bit proud, much closer to me than before.

A reflection on safety in music therapy with young people who experienced attachment trauma

One can read that:

physical and emotional safety, being protected from both internal and external threats, is a key element of trauma-informed practice. Therefore, music therapists should strive to create a therapeutic environment in which the client feels physically and emotionally safe to minimize triggers. (Heiderscheit & Murphy, 2021, p. 2)

Thinking about Maja's performance, the question arises: Was this event emotionally safe for her? The triggers were there – the mother, the stressful situation, and emotional music. Was there any protection? To me, during the performance, it seemed very unsafe. Moreover, I felt guilty seeing her crying on the stage. But apparently Maja felt good about it. All of this artificiality – the stage, the lights, the audience, the borrowed music – may not be a trigger, but a 'bracket' for reality that Maja needed in order to formulate this very private, deeply emotional message, to connect with her deep feelings. The stage, unexpectedly, was safe, creating physical distance. Maybe the people around watching also brought both safety and validation, or made the experience matter more? Or possibly Maja knew that with the audience, on the stage, being committed to perform, she would be forced to do what she planned and found this force helpful. Mastery is very important in treating children who experienced trauma according to van der Kolk (2003). During the concert Maja had a chance to be in charge, be calm enough to focus and accomplish her goal: to communicate what she felt was important.

This situation had one more aspect: It gave her mother no opportunity to respond. Being there was safer for Maja than talking to her mother in private. Apparently, also not talking to me about how she felt about the song before the concert was safer than sharing the emotional content. The reasons might be very different, however. "It is an apparent paradox of human development that precisely insecurely attached people [...] strongly activate their unconscious attachment system in situations of strong psychological or social stress" (Lahousen et al., 2019, p. 9). Maybe Maja felt that she needed this stress arising from being on stage to work on her attachment issues. Baylin and Hughes (2016) say that:

reawakening the suppressed need for connection in maltreated children is one of the most moving experiences therapists and parents can have. Scenes in which children, closed off for years ... start to feel the pain of their prolonged isolation rising up through their defensiveness and urging them to finally seek comfort from a caring adult, can be stunning to witness. (pp. 157-158)

In Maja's situation it was the scene, both as the stage, and a scene she made.

But if one's attachment system is activated by strong stress and reawakening the need for connection means pain, how can it be done safely? What is safety in these circumstances? Different psychotherapeutic approaches interpret safety in various ways. They agree, however, that the therapeutic safety should be sufficient, not perfect, to leave space for frustrations and insecurities promoting growth and resilience (e.g., the humanistic concept of safe emergency, or the

psychodynamic idea of necessary danger; Podolan, 2022). However, it would be assumed that the risks are assessed by the therapist. In Maja's case, she took the responsibility and transformed through stress and pain. Regarding the music therapy process, as proposed by Sokira et al. (2022), at some point its purpose is:

the telling of the individual's story. This includes sharing and connecting to the lived experience of trauma The goal is to normalize the clients' responses, for the client to feel heard, and to help the client connect current struggles with their traumatic experiences. (p. 14)

Maja shared and possibly became connected to the trauma. She was also heard. It was done on her terms.

Case vignette 4 – Ludwika's work. On uncertainty

I am a middle-aged music therapist. I have been working with teenagers who experienced attachment trauma for about 15 years. When I come home from work in the evening, I tend to talk to my husband (thanks for his patience!) about what happened. I don't give him thorough information on the clients, I avoid the context, but I report on moments that revealed something. At the beginning of the conversation (mostly monologue), I am usually not sure what it is that will be revealed, this material becomes clear while telling the story. While I talk, the experiences start to come together and become whole, to make sense, sometimes on an intellectual level, sometimes on an emotional and intuitive level. It helps me to integrate what has occurred and to navigate the following sessions.

Where am I in this work? What do I experience? Processing it seems to be a difficult task and naming it, ordering it, even more so. I wonder about my own attachment issues, the possibility of vicarious trauma in my work, and other aspects of my life that impact me as a music therapist. Sometimes, when I hear my clients' stories, I cry, but wonder if I should cry. Other times I do not cry and wonder why I do not. I try to be aware of my own emotions and regulate them. Nevertheless, I am a mother and working with children whose stories are so painful makes me feel guilty from time to time. For what I do, for what I do not do, and for the whole world around that allows it to happen. At the same time, I feel inspired by being with my clients. I am amazed by their strength, sense of humour, ability to grow, and perceptions of the world. Often, I feel we go through changes together; they are working on their issues, and I am changing with or because of them.

I am uncertain of what is going on during some sessions. Sometimes I even feel lost. In my personal life, I tend to be organised and, some friends would say, controlling. Yet, surprisingly, I trust this uncertainty during the sessions. Uncertainty is a part of my job. Am I safe saying it out loud outside supervision? How much do we, as therapists, not say – to feel safe, trusted, and professional?

A reflection on the perspective of the therapist working with clients with attachment trauma

The acceptance of uncertainty seems to be a most important factor, which actually gives stability and confidence to the therapist. It transfers then to the young clients, who can – paradoxically again

– start feeling safe, trusted, and trusting in the environment, which allows for keeping part of the work between the lines or even within the lies.

The self awareness of the therapist is important. Considerable literature on attachment or attachment styles, and how attachment determines people's functioning or the way they form relationships is available (Santona et al., 2019; Sheinbaum et al., 2015; Simpson & Rholes, 2017). Typically, these findings are considered while reflecting on clients' issues. However, therapists have their own attachment styles, and some studies suggest that these might influence the therapeutic alliance (Bucci et al., 2016). Recent findings show a complicated picture, where the attachment style of the therapist would not necessarily affect the therapist's ability to build an adequate therapeutic relationship but could interact with their emotion regulation abilities (Petrowski et al., 2021; Ruiz-Aranda et al., 2021). This seems to be particularly important in work with people who experienced attachment trauma, where attachment issues play a crucial role in the therapeutic process. Therapists' personal ways of relating to others and their possible responses to behaviours related to different styles of client attachment should be carefully monitored through self-reflection and supervision.

Witnessing trauma that has occurred to others is one of the types of exposure criteria listed in DSM-5 (American Psychiatric Association, 2013). Studies suggest that, indeed, the impact of working with trauma can be profound and complex for therapists. This can include both being close to the tragedy and pain, and also observing clients' resilience (McNeillie & Rose, 2020). Therapists themselves might experience growth from accompanying people as they overcome their traumas (McNeillie & Rose). Similarly, researchers involved in studying trauma are at risk of vicarious negative trauma reactions and, simultaneously, have an opportunity for posttraumatic growth (Berger, 2021).

These findings received confirmation in the last vignette. On the subjective level, I try to be aware of my own attachment-related behaviours. I do not see them impacting the therapeutic process heavily, but they obviously might. Regarding the processing of clients' traumatic experiences and the risk of secondary traumatising, the research results fit my perceptions well. Although the work touches the emotional aspects and can be exhausting, it also brings the potential for change, for both personal and professional growth.

FINAL REFLECTIONS AND QUESTIONS

Coming back to van der Kolk's (2003) suggestion, "traumatized children must be helped actively to overcome their habitual fight/ flight/freeze reactions by engaging their attention in actions that (1) are not related to trauma triggers and (2) provide them with a sense of mastery and pleasure" (p. 310). In the three cases above within the interventions suggested by therapist (songwriting, improvised storytelling, performing pop song) the triggers were not unavoidable. There was no directing the work towards relating to trauma. However, the young people decided to go this way. Maybe they felt stable enough to express their experiences in different ways and build the distance they needed. Was the sense of mastery and pleasure included? In some moments, probably so. In others, not so much. But like with the concept of trust and safety, how should we understand and evaluate pleasure? How did crying on the stage feel for Maja? I will never know, but questioning

basic concepts and reconceptualising them seems to be necessary when working with people who experienced attachment trauma.

Scrine and Koike (2022) proposed reconceptualising safety as a complex, ongoing relational practice. It should also be highly individualised. Similarly, trust should be viewed as a fluid category, rooted in personal circumstances, as something that is not stable and objective, but based in interpersonal dynamics. The vignettes presented suggest that both safety and trust go beyond the physical and emotional environment, protection from triggers, and keeping steady boundaries. In practice, they require a more subtle and flexible approach that needs to be highly personalised. As Scrine (2021) suggests, assigning vulnerability might cause further harm, and protecting from triggers might stop clients from doing what they need to do.

Perhaps sometimes, the more people who experienced trauma trust you, the more they lie to you, hoping that the trust is deeper than words, as in Peter's and Vera's situation. Or, like Maja did, they trust you enough to trick you into doing something that they need, like organising her performance. Maybe sometimes the distance created by not telling the literal truth makes it possible to build a relationship and have a shared experience. It is like a safety valve, a buffer that can cushion the fall - something for which young people with attachment trauma are always ready and which they anticipate while relating to others.

Trust can go with acceptance and send a powerful message. Relating to Peter's words, if you trust in someone's lies, you show acceptance in a way. But how does that go with safety? Can you feel safe with someone who trusts in all your lies? Does it mean this person trusts everyone?

Relational needs of clients who have experienced attachment trauma are typical goals for music therapists. Bensimon (2020) listed the relational needs of these people as: the need for recognition, acceptance, emotional witnessing, emotional responsiveness, safety, trust, and for someone to reach out to them. But what about when the need for recognition and acceptance leads the client to lie and to jeopardize trust, as in Peter's situation? What if emotional witnessing and emotional responsiveness are too heavy and not safe for a young person during the sessions, or so great that the therapeutic environment is not broad enough, and the client needs the whole concert audience to be the witness and responder, as in Maja's situation? Is there any hierarchy of the relational needs? Considering Bensimon's other study (2022), referring to integration, is it possible to integrate the events and life stories by narratives which, on a literal level, are not true?

One of the aims of the current paper is to present voices of young people who experienced trauma and my own, as a clinician working with them. "From a trauma-informed perspective, empowering clients means providing choices so that they can have a voice in their therapeutic process and the overall treatment" (Heiderscheidt & Murphy, 2021, p. 2). On a practical level, offering a choice is simple. What would you like to do? Sing? Play? Offering a choice is, however, only the beginning. Then comes the voice. So what do the clients use their voices for? At times, for lying. Or crying, or singing. Hearing and understanding the voice is the next step - a big responsibility, and quite a challenge for a clinician. As Hillman et al. (2022) noted, participant perspectives have been underrepresented in research on music therapy and trauma. But what tools or measures can be used in such a delicate, sensitive context?

Vera used her voice while repeating the story of her adventure, mixing reality with additional elements, needing to feel that she could impact other peoples' emotions. Maybe she believed that,

without this enhancement, the pure true story would make no impression, and no one would care. Peter and Maja used 'voices' of other people. In quite an honest way, like Maja, who chose the song from the pop repertoire, or cheating and attributing to oneself someone else's property, like Peter, claiming his brother's song as his own.

In this article, I have used my voice to share the vignettes and reflect on them. You can read about Peter, Vera and Maja as they were filtered by my sensitivity. You can listen to me, mostly my questions, doubts, and tentative interpretations. The voices of young people were physically heard during our sessions, cited literally in the vignettes, but I am not sure if I understood them correctly. The expressions had to be interpreted on many levels. Interpretation on the intellectual level was not enough; empathy and intuition had a role to play.

While interpreting, was I giving them voice or simply using their voices? I will never know. Perhaps the only strategy to keep working and not getting drowned in doubts and questions is to trust the uncertainty.

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Ελληνική περίληψη | Greek abstract

Εμπιστεύοντας την αβεβαιότητα: Μουσικοθεραπεία με νέους που έχουν βιώσει τραύμα προσκόλλησης

Ludwika Konieczna-Nowak

ΠΕΡΙΛΗΨΗ

Το ψυχολογικό τραύμα έχει πρόσφατα λάβει αυξημένη προσοχή στη μουσικοθεραπεία, με αποτέλεσμα τη δραματική αύξηση των δημοσιεύσεων σχετικά με αυτό το θέμα. Ωστόσο, η φωνή των θεραπευτών και των συμμετεχόντων δεν αντιπροσωπεύεται επαρκώς στη βιβλιογραφία. Το παρόν άρθρο αποτελεί μια προσπάθεια να καλυφθεί αυτό το κενό, παρέχοντας παραδείγματα από την πρακτική μέσα από αφηγήσεις που απεικονίζουν την οπτική του μουσικοθεραπευτή για τη δουλειά, τις εκφράσεις των πελατών και τις σχέσεις. Μέσα από σύντομα περιστατικά από συνεδρίες μουσικοθεραπείας, οι αναστοχασμοί για το έργο ενσωματώνονται με σχετική βιβλιογραφία. Τα περιστατικά καταγράφουν στιγμές όπου βασικές έννοιες, όπως η εμπιστοσύνη και η ασφάλεια, της πρακτικής με επίγνωση του τραύματος, τίθενται υπό εξέταση και

συζήτηση. Λειτουργούν ως αφετηρία για τη σύνδεση θεωρητικής γνώσης με βιωμένες εμπειρίες και στοχεύουν στο να ευαισθητοποιήσουν τον αναγνώστη με τρόπο διαισθητικό και συναισθηματικό, αλλά και διανοητικό.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

τραύμα προσκόλλησης, μουσικοθεραπεία ενημερωμένη για το τραύμα, ασφάλεια, εμπιστοσύνη, φωνή

ARTICLE

Understanding the silences, not just the sounds: An exploration into music therapists' meaning making of silence in improvisational music therapy

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ABSTRACT

Silence is a common experience in music therapy, potentially rich in meaning, however there is limited literature available about silence within improvisational music therapy. This article draws connections between musicological, psychological, phenomenological, and music therapy literature on: typologies of silence, silence as an intersubjective phenomenon, and silence as a space for reflection and processing. The importance of meaning making and silence in improvisational music therapy is explored through semi-structured interview data and Interpretative Phenomenological Analysis (IPA). The IPA interview analysis produced three superordinate themes, developed by the primary author and reviewed by the secondary author, comprised of ten subordinate themes: Anxiety and Tension In, and After, Silence; Silence as a Space; and Clinical Considerations of Silence. Connections are made between the analysis of participant interviews and existing phenomenological, musicological, psychotherapeutic and music therapy literature on silence. The discussion finds that the therapist's perceived strength of the therapeutic relationship is key to the experience of silence in the therapy environment. It also outlines silence as a space of reflection and self-actualisation, and as a facilitative aspect of clients experiencing empowerment and authenticity. This paper also presents a theory, based on the interview data gathered, providing a grounded theory angle. The theory offers a model of the continuation and cyclical recontextualisation of meaning from the musical, into silence, and beyond. The study identifies implications for practice and further opportunities to solidify existing theory and develop concepts unique to silence within music therapy.

KEYWORDS

improvisational music
therapy,
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INTRODUCTION

During Garrick's training, he experienced many instances of silence that were therapeutically informative to the clinical work with his clients. These moments raised unique questions, anxieties and experiences that were not present in individual musicking or during musical parts of sessions.

Vignette

I'm sitting on the floor in the lounge area of an inpatient adult mental health ward. Across from me is the only patient that has attended the open group. He sits opposite, holding an ocean drum. I think: "he has managed to make an ocean drum perfectly silent." I think: "perhaps I should break the silence, maybe he's waiting for me to take the lead?" I feel tense. "What does the patient think and feel right now? Is this anxiety mine? Am I feeling some sort of countertransference? What would a 'real music therapist' do?"

In the vignette, the first author cannot understand the meaning of the client's silence. However, the client is not the only person in silence. The author is as accountable for the silence in the space as the client. Some of the thoughts in the vignette point to why they engage in, and perhaps perpetuate, this silence. Silence is a common experience in music therapy, one that can be rich in meaning. Within improvisational music therapy literature there is limited writing on the meaning and use of silence within sessions (Sutton, 2002, 2005, 2006, 2023; Sutton & De Backer, 2009); this study explores music therapists' experiences of silence and forwards theory on some of the functions and uses of silence in clinical work. Literature on silence, its roles and uses, across fields related to clinical music therapy practice were reviewed. The following sections discuss silence from phenomenological, musicological, psychotherapeutic and musico-therapeutic perspectives, drawing connections between the different disciplines. We begin with how silence has been categorised across different disciplines.

Typologies of silence

Conceptualisations and categorisations of silence as a heterogenous phenomenon exist in phenomenology, musicology, and psychotherapy. Dauenhauer's phenomenological analysis of silence (1980) describes three typologies of silence that exist within discourse between two or more individuals. These categories: *Intervening silence*, *Fore and After silence*, and *Deep silence*, describe silence as an active, communicative, phenomenon between the self and others.

- Intervening silence: Periods of silence between units of sound to distinguish one from another.

- Fore and after silences frame a sounded expression that is a self-contained unit of information.
- Deep silence is uniquely unbound to any specific utterance and yet still exists in contrast to utterances.

Within music, Clifton posits that silence “participates in time, space, and gesture” (1976, p. 163), imbuing emotion and meaning into music.

- Temporal silences affect the listeners perception of time; perceived as a clear distinction between sound and non-sound, this silence can be as simple as all musicians ‘playing’: a rest simultaneously.
- Spatial silence is the (dis)use of voices across registers; Clifton likens this to “empty spaces in the sculpture” and refers to this silence in the context of the form of the music (p. 171).
- “Silences in motion” (p.178) impart the sensation of musical motion happening within the rests and silences of the music.

As above, Clifton and Dauenhauer both describe types and functions of silence in their respective works on the subject. In psychotherapeutic theory, Levitt (2001a) identified the tendency for silence to be treated as a homogenous phenomenon. Through an exploration of clients’ experiences of silence within talking therapies, Levitt (2001a, 2001b, 2002) forwards an inventory of seven categories of silence grouped under three highest order categories:

- Productive silences
- Neutral silences
- Obstructive silences

Levitt argues that silence is a heterogeneous experience for clients in psychotherapy, challenging simple or homogenous understandings of silence in therapy. Across phenomenological analysis, musicological theory, and explorations into psychotherapy clients’ experiences of silence, there is a consistent ability to separate silences into discrete categories. The phenomenological and psychotherapeutic categories described by Dauenhauer and Levitt are primarily separated by the experience of silence, with the theory of its function being based upon the affective experience. Clifton’s analytical approach towards musicological silences is informed by Heidegger (1962) and Gusdorf (1965). Whilst the paper is primarily interested in describing and exploring the musical theory of each of his typologies, Clifton uses sensory descriptions of silences to introduce the reader to each concept, relying on an affective recognition within the reader to draw them into the mechanics of the music. Each set of typologies explored relate to silence as a phenomenon within their respective fields and each author draws upon the reader’s experiences of silence(s) and their affective shapes to describe its forms and functions. The authors cited throughout use these shared experiences of silence(s) to communicate with the reader, exposing silence as an intersubjective phenomenon that is both implicit in the description of the typologies and explicitly described in within music therapy, psychotherapy, phenomenology and musicology.

Silence as an intersubjective phenomenon

Using Conversation Analysis, Sutton (2023) notes that silences threaten the stability of discourse in spoken conversation but act as a feature that maintains the attention of the listener in music, providing cohesion to the intersubjective experience. Dauenhauer (1980) privileges music as being one of few modalities that can maintain a stable *sense* of communication with two or more people engaging in simultaneous discourse. He positions emotional or psychological security as an antecedent to codiscourse, requiring the individual to relinquish complete autonomy to enter into an intersubjective relationship. Trevarthen (1980) defines intersubjectivity as the knowledge of and interaction with another's internal state, while Stern (2000) theorises that this capability develops in children between seven and nine months. Stern (2010) proposes that we create implicit relational knowledge through dynamic forms of vitality, multimodal expressions of the dynamic contours of inner states. For example, an emotion such as anger might manifest through various vitality affects. It might "explode," "ooze out," "sneak up" or "be cold" (p. 28). Meyer (1961, p. 35) conceptualises that music contains affective contours which manifest emotions in the audience through "embodied musical meaning." Meyer and Clifton (1976) describe the role of silence in these affective contours in manipulating anticipation, anxiety, and tension, suggesting that musical silences not only contribute to the experienced musical meaning but also contain information that is vital to the structure of music's affective contours.

Music therapy improvisation carries potential for intersubjectivity to manifest between client and therapist using music as a mode of expression; the therapist can interpret music and experience to infer the client's experience of themselves in the world (Pavlicevic, 1997). Sutton (2006) cites Flower's (2001) assertion that silence in music therapy is an informative phenomenon that may describe something about the connection between therapist and client. Analysing improvisational music with conversational analysis tools, Sutton (2002) proposes that musical silence overlaps with conversational silence for the purpose of modulating tension and emotional affect. Within talking therapies, Lane et al. (2002) identify silence as a key communicative factor between the client and therapist, describing it as a space in which clients impart emotional messages through transference and countertransference processes. They also discuss the ways in which the therapist's silence may be interpreted by the client; suggesting the impacts of silence in therapy can be helpful and harmful to the client's therapeutic journey, mirroring the findings of Ladany et al. (2004) and Levitt (2001a, 2001b, 2002).

Sutton, Clifton, and Meyer describe musical silence as a phenomenon that modulates the listener's affective experience. Through the lens of Stern's dynamic forms of vitality, it is possible to understand how these affective contours communicate information between individuals. Where silence plays a part in the affective structure of music, a connection can be made to Lane et al.'s (2002) findings of silence imparting emotional messages between the therapist and client. Silence is shown to have an active function in the intersubjective experience between people in music making and conversation.

Considering the myriad typologies of silence described in the previous section it is possible to infer that the active phenomenon of silence fulfils many communicative functions in the intersubjective relationship and experiences between individuals, as found by Ladany et al. (2004)

and Levitt et al. (2001a, 2001b, 2002). An exhaustive description of the affective experiences and functions of silence would be far outside the scope of this paper. However, a function of silence that is pertinent is the role it plays in affective processing, cognition, and reflection.

Silence as a space for reflection and processing

As referred to in Dauenhauer's (1980) three typologies, After-silence is a space for processing and reflection. In music, Potter (2017) suggests that silences can be communicative; communicative silence relies on timing and a balancing of predictive and reflective implications from the performer. Silence invites the listener to process what has happened in the music and creatively reconstruct the performers' meaning from the audience's subjective experiences. Potter's listener holds the music in their mind, reconstructs the sounds and affective contours, and engages in meaning making; this is a space in which affective experience meets cognition, developing insight through reflection.

Psychotherapy also positions after-silence as a space of reflection. Ladany et al. (2004) found that, in a study of 12 therapists, all participants used silence for client-focused reasons, such as the facilitation of a reflective state for clients. Elson (2001) writes that when client and therapist are in a state of silent attunement there is opportunity for both to reflect. The silence after the therapist offers their interpretation is a space in which clients may reflect and begin to engage in therapeutic processes self-observation, self-determination, and transformation. We liken the interpretation of Elson's therapist to the musical material that is offered by Potter's (2017) performer. Both are taken in by the 'audience' whose members then engage in a process of reflection and reconstruction of that material, resulting in a more complex and cognitive understanding of their experiences. Within the context of music therapy, Sutton (2023) states that silence opens a space for thought and reflection in both analyst and patient.

Across the three disciplines of musicology, psychotherapy and music therapy there is a convergence in how silence is conceptualised as a "space" that is used for affective processing and reflection. All the authors above describe a process in which an intersubjective relationship transitions from sound to silence. Affective experiences relating to the audible (and, perhaps, inaudible) material in the relationship continue for the individuals throughout this silence, drawing a line back to the way Clifton (1976) describes "Silences in Motion." Clifton describes a "Silence in Motion" as a lack of sound in music (silence), which is bridged through the experiencing body of the listener. Clifton cites a common example of this as music that is easily danced to, highlighting the bodily movement of the listener as the bridge that provides the continuation of motion in the music. Clifton (p. 178) cites Mahler's Fifth Symphony as containing a silence in which there is not only motion that is bridged by the listener, but the listener experiences the motion as changing direction. These silences impart real, and sometimes complex, affective experiences to the listener that allows a continuation of motion, a carrying forward, through into the next audible moment. Potter (2017) and Elson (2001) describe an affective experience at a point where there is no motion in the discourse. The literature illustrates an important aspect of the function of silence in reflection and affective processing by highlighting that as the discourse transitions from sound to silence, the affective experience also makes this transition with the individuals. In this way silence is not thought of as an "absence of," but as a continuation of the intersubjective relationship.

A common theme between Elson, Dauenhauer and Potter's work is the chronological placement of a reflective silence; it being at the end of an intersubjective experience. There is an implication in their works that reflective meaning-making cannot occur during an experience. van Manen (2016) supports this from a phenomenological perspective, positing that if one tries to reflect on the emotional experience in the moment then one fundamentally changes or dissipates the feeling that is being focused on. Therefore, any meaning-making of an experience must be retrospective at the point of cognition; even if one is still "in the music," one is no longer in the same experience of the music.

From the literature discussed, there is overlap in musicological, phenomenological, and psychotherapeutic interpretations of the roles and functions of silence, providing areas which may inform music therapists' interactions and interpretations within clinical work. Due to the multi-faceted conceptualisations of silence as a component of intersubjective communication, a "space" for reflection, and as an active choice by individuals, it is pertinent to explore the different ways in which silence interacts with the therapeutic process. Due to the comparatively limited literature in the area, it is valuable to expand the understanding of silence within the music therapy space. By engaging with therapist's experiences of silence in clinical work it is possible to build a more comprehensive view of the functions and roles that silence plays in music therapy.

RESEARCH QUESTION

We aim to explore the following question: How do music therapists understand their experiences of silence within improvisational music therapy sessions?

METHODOLOGY

This research took place between 2021-2022 as part of the first author's MA Music Therapy degree. Garrick Wareham is the first author and the primary investigator. Luke Annesley the second author, acted as supervisor during the degree and reviewer on completion of the first author's degree.

Study design

A qualitative study design based on interview data was chosen to explore the personal experience and meanings of silence that therapists has experienced during clinical work. Due to time limitations, other data gathering methods such as Interpersonal Process Recall using recordings of clinical work was not used, with the acknowledgement that this would provide additional rich data. Data was gathered through semi-structured interviews, which were transcribed and analysed using Interpretative Phenomenological Analysis (IPA) to develop and explore the data. IPA uses participant experience, which is then interpreted (Smith & Osborn, 2015). IPA's idiographic approach determines selection of participants, prioritising the homogeneity of participant experience and richness of depth of the data over sample size (Smith et al., 2009). IPA's data analysis utilises the hermeneutic cycle (Smith et al., 2022), deriving meanings from the data by moving between contexts, focusing on specific parts (words, sentences, paragraphs) and then focusing on the whole (full transcript) and

back again (Montague et al., 2020; Smith et al., 2022). Applying this cycle allows for an inductive approach, beginning with a subject of study and allowing data to inform understanding.

Sample size and recruitment

Recruitment criteria for participants required them to be currently practising or to have practiced improvisational music therapy as a Health and Care Professions Council (HCPC) registered music therapist within the last two years, with no minimum amount of practice required. The HCPC is the regulating body for 15 health and care professions in the United Kingdom; “arts therapists” are one of the professions under the purview of the HCPC, with “music therapist” being one modality within arts therapies (HCPC, 2020).

Calls for participants and digital posters were distributed through personal social media channels and emails were sent to gatekeeper organisations, such as the British Association for Music Therapists, with the request to disseminate calls for participants. Music therapists with publicly available email addresses or known through personal contacts were also approached; ‘snowball sampling’ through personal contacts was also used. A total of three participants were recruited through calls to action and personal outreach, all experienced professionals (5+ years active clinical work) across a range of client groups including forensic music therapy, child palliative, older adults and Autism Spectrum Condition (ASC) clients. All participants interviewed trained as music therapists in the UK; P1 described their work as integrative but strongly psychodynamic, P2 as integrative between psychodynamic and humanistic, and P3 as psychoanalytically informed music therapy. Interviews were between 45 minutes and one hour in duration.

Interviews and transcription

The first author conducted semi-structured interviews in the Spring of 2022; Microsoft Teams was used for interviews to include the geographical range of participants, enable use of auto-transcription services (Balushi, 2018), and allow participant safety concerns regarding COVID-19 in the United Kingdom to be respected. Participants consented to video and audio recording for the purposes of transcription as well as the use of the Teams text transcription function. The interview schedule contained nine open-ended questions, along with follow-up questions and prompts to encourage participants to expand freely on their initial answers. Interview schedule development was guided by Braun & Clarke (2013) and Smith et al. (2022).

Verbatim transcriptions from Microsoft Teams were checked against the video recording of the interview. Pauses, gestures and laughter that added contextual information or seemed important were noted in the transcriptions (Smith et al., 2022). Some “urms” and “ahhs” were removed from final transcriptions to provide more legible quotes to be identified as units of meaning for coding.

Coding and themes

Transcripts were separated into discrete units of meaning and imported into a Microsoft Excel spreadsheet, allocating each a general timecode and quote number. Notes, reflective links to theory,

expanded interpretations, and experiential statements were created alongside each unit. Experiential statements from all interviews were collated into a single sheet from which superordinate and subordinate themes were developed. During the process of theme development, the transcripts were repeatedly consulted, allowing for reconsideration of initially discarded data as part of the hermeneutic cycle as described by Smith et al. (2022). In summary, the analysis followed these steps (ibid):

- Transcription & Checking
- Several (minimum of three) reads of transcripts
- Import into Microsoft Excel & initial separation into units of meaning
- Exploratory notes on transcripts
- Construction of experiential statements
- Clustering experiential statements into subordinate themes
- Collation of subordinate themes from all interviews
- Development of Superordinate Themes

Reflexivity

It is important to acknowledge the author's role as the researcher in an interpretive process of data collection and analysis; the experiences and understanding of the subject inform the construction and specification of the interview schedule. The interpretation of the data provided by participants is understood through the context of preconceptions based on personal experience and understanding of theory of the authors. The first author identifies as white, middle class and male. He has a musical background in classical, jazz, and experimental electronic music. Through his undergraduate degree in music technology he was exposed to experimental compositions and sound installations which have contributed to a subjective understanding of the use of silence and ambient sounds as parts of music. Space was made for reflective notes as well as use of the hermeneutic cycle and the secondary author's own review to hold interpretations accountable to the context of the interview data.

Ethics

This research was approved as low-risk by the Psychology Ethics Committee, University of the West of England (UWE). Recollection and discussion of potentially distressing experiences was considered the prevalent risk, mitigated by provision of support options for participants and research supervision for the first author. Information sheets, consent forms and demographic questionnaires were sent to interviewees via Qualtrics before time of interview. Demographic questionnaires collected basic information on the participants to maintain records of age, race, gender, disability, number of years of clinical practice and music therapy approach, to provide relevant context to the experiences described by participants. During the coding process, names were anonymised and other data, including pronouns, were removed or replaced with gender-neutral choices unless considered contextually relevant. Data for client groups that the participants work with was not

collected; participants provided client group information based on the experience they described. Some interviews covered a range of experiences with different client groups.

FINDINGS

Three superordinate themes, comprised of ten subordinate themes, were developed from data provided by three participants: Anxiety and Tension In, and After, Silence; Silence as a Space; and Clinical Considerations of Silence.

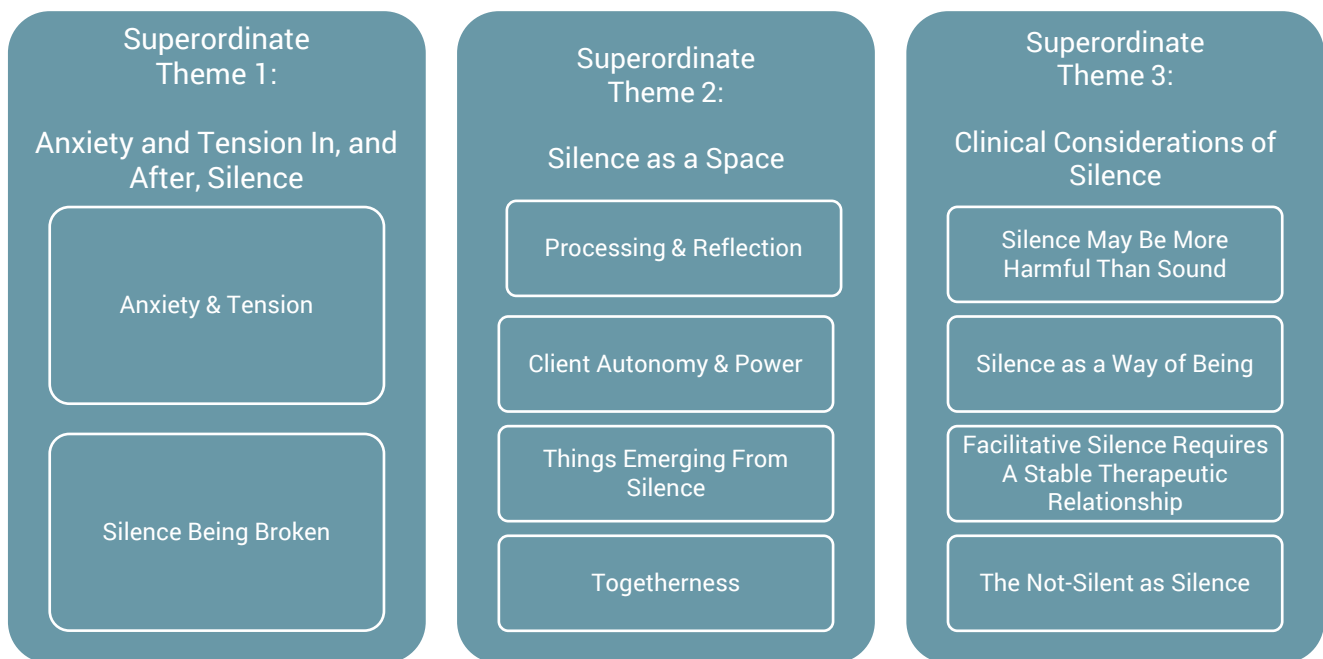


Figure 1: Superordinate and subordinate themes

Theme 1: Anxiety and tension in, and after, silence

Recounting moments of silence, participants described feelings of anticipation, excitement, physical sensations of anxiety, and active thoughts that questioned their choices in the session were common. Another common anxiety was the perception of outside observers; their judgement that silence meant that nothing was happening.

A series of thoughts described by Participant 1 (P1) demonstrates internally focussed anxiety:

[...] 'how long should I wait?' The other [question] I think would have been, 'Should I move the drums to their hand so they don't have to move quite so far?' You know, 'Is it rude for me to expect them to move their arm from here all the way down to there?' Or 'if I had the drum up here, it would be so much easier,' So I suppose I was thinking '... have I made an error here, and have I committed to something that's actually not entirely helpful for them?' (P1)

Participants only mentioned experiences of anxiety when in silence. Although the interview questions were specific to experiences of silence in clinical work, participants freely brought their musical experiences preceding silence into the discussion, no comparisons to experiences of anxiety when musicking were made. Participants also described anxieties that were externally focussed on the client's wellbeing and present experiences of the silence; the client's ability, or perhaps the capacity for the relationship, to "survive" the silence. Despite anxious impulses, participants described clinical scenarios where they resisted breaking the silence:

[...] but I just thought on that occasion that it could be clumsy, it could be that I wouldn't find the right words, or they wouldn't ring true for them... and then speaking, having words, and thinking 'no, I'm not going to say that'... (P3)

Even when P3 found words, they make an active choice to stay in silence and anxiety, commenting that it was important for the client to have the experience of silence in the way they needed to. P3 described that, in their experience, some therapists may stay silent because they do not have anything to express, or don't wish to put "their music" ahead of the client's.

When clients did break the silences, participants described sensations of tension and relief. Anxiety was alleviated when client's broke silent moments. "... a sort of sense of relief, because I knew then that they would be alright, but in the silence I hadn't been so sure..." (P3)

P3 described anticipation, waiting on tenterhooks, and a fear for the client in their moment of silence. This anxiety was alleviated in their new experience of certainty that the client would be alright.

Theme 2: Silence as a space

Participants commonly used silence to process the content of the musical experience: "I was thinking about the music and reflecting on that, thinking 'oh what just happened?' and hearing it back in my head" (P3). Silence after musicking with a client was described as providing therapists with an opportunity to reevaluate the music within the context of the whole performance. Participants noted that this provided further insight and could help contextualise their countertransference. Similarly, participants believe clients also use silence to process and reflect: "[...] often it's the silence bit which is where people get the insight and the perception of what might have changed or what they might have experienced in music." (P1). The participants considered silence after musicking as a time that clients can feel changes and experiences. Participants made no obvious distinction between their own and their clients' use of silence as a space for reflection.

Participants recounted their experiences of silences seeming to provide space for clients to experience autonomy and control, making their own decisions with as little coercion or expectation as possible:

[...] that's sort of invading the silence if you're inviting someone, or asking if somebody wants to play something... And if you break the silence by perhaps asking them again or asking something else, or moving... anything that you do is potentially invading the silence that they need in order to make that decision and in order to work out what to do next. (P1)

The use of “invading” as an action that someone other than the client might do suggests that some silences facilitate a sense of ownership. Here, invasion implies a removal of autonomy, power, and resources against the will of the occupant. P1 described the silence as needed “in order to make that decision,” implying that the silence is owned by the client. P3 described a similar intention:

I think the silence part in the context [of the work with the client] is about also trying to communicate something about how, despite all the feelings of abandonment, and not being heard, and everything, that actually they can make things happen. (P3)

Use of “abandonment” and the isolation of “not being heard” evoke an impression of the client’s powerlessness. P3 considered that allowing the client the experience of making things happen in an uninterrupted way was the most important thing at the time. Events were often described as “emerging” from silence, with attention drawn to non-musical events such as speech and action. Participants described that new ideas and statements from clients appeared after silences. “I just was quiet, and I feel out of that they were able to articulate some things not said before.” (P3).

Participants believed that silence gave the client room to share experiences that had not been previously made explicit within therapy:

[...] what's emerging from it is coloured and is shaped by what's happened in that silence, whether it's a physical thing, whether it's an emotional thing, whether it's an anxious silence, and a kind of waiting and a nervous energy, or a kind of peaceful silence... (P1)

P1 implied that there is something meaningful about the connection between experiences during silence and things that emerge after these silences.

Silences regarded as therapeutically meaningful during sessions tended to contain a sense of togetherness between the client and therapist. In the work recounted by P2, which revolved around developing a tolerance for silence, this seemed to be crucial to the therapeutic process:

[...] being in that moment where you are quiet together, but it's a safe quiet, and it's a quiet that feels OK and safe, and then it's broken, and that's still safe; that sense of containment and safety still remains. (P2)

The transfer from a togetherness in sound, to togetherness in silence and back to togetherness in sound seemed to be a key aspect of the experience. P2 suggested that they thought the emotional state of the client being transferred from sound to silence allowed the client to experience a way of being, feeling contained and supported by the therapist, which would have otherwise be intolerable.

Theme 3: Clinical considerations of silence

Participants regularly expressed that they perceived clients as distressed or overwhelmed by experiences of silence. These experiences were considered to not have any beneficial therapeutic effects. Participant's also discussed clients using silence as a way to isolate themselves from others, "[silence] can be the safe space or the frightening space, and often when people use it for the safe space... the whole purpose is to draw them out of that silence and that isolation and retreating from others" (P2). P2 observed that in moments of client self-isolation a part of the therapeutic process would be to encourage relationship with the therapist. P3 described that sometimes the therapist's silence could exacerbate the client's isolation: "[...] there could be that point where it could be so helpful to help someone make music, if it's music therapy and that they need that trigger, you could offer that...". Musicking can facilitate a therapeutic relationship where silence cannot. As client groups and pathologies vary, P3 made a strong case that when considering any approach or tool it is always necessary to refer to the client's reason for being in therapy.

A stable therapeutic alliance was regarded as foundational to a sense of 'togetherness' in silence. P2 summarised, "too much silence and no alliance, if there's too much silence, there's no alliance...". P2 considered too much silence within early therapy sessions or where the therapeutic alliance was not stable enough as a to hinderance to the therapeutic alliance, or a feeling of togetherness. The experiences described by participants were predominantly within the context of longer-term therapeutic work where a reasonably strong therapeutic foundation had been established, "[...] silence feels like something that should be a shared and agreed experience in some ways after a sense of safety and trust is built." (P2)

A therapeutic relationship that contains trust and safety for the client, as well as empowerment to negotiate boundaries with the therapist, was seen as crucial for clients to be able to engage in silence where therapeutic processes can happen. This foundation is key in facilitating clients' use of the silence for processing, introspection, and their ability to 'survive' silence.

Creating an ability for inner stillness, or the tolerance of internalised silence, could be considered a goal for therapists and clients to work towards. Developing an internal silence was important for P2's work with the client; the capacity to experience silence was seen as important for this client as an opportunity for introspection and reflection:

[...] there was more of a silence within, like a calm, a stillness that came across... but I guess in terms of what that meant for him, it was massive because there was an ability for him to sit with himself which allowed for more clarity of thought and the ability to reflect... that allowed for more space and more introspection and time to really think about what was going on. (P2)

Participants also described how pathologies that are physically or cognitively restrictive may result in silences that are not self-actualising or benevolent. P3 related that a therapist may be able to respectfully acknowledge these ways of being through their own silence:

[...] patients might be silent for all sorts of reasons... someone could have locked in syndrome, a form of brain damage or form of dementia, or had a stroke and that could be a really important part of the therapists' silence, somehow to acknowledge. I think if you're with someone who can't speak or who can't make sound it's respectful also to be silent... (P3)

P1 poses a concept of "relative" silence, reasoning that no environment can ever be truly silent within the human experience; there will always be sound. P1 elaborated how music may qualify as silence in this way:

And then the new relative silence is this little texture that you're providing as a music therapist... something to bring into it that, that's not too defined by what I'm playing? So, like open fifths or something? So, you're not choosing major or minor. You're not putting a rhythm in... I would say that you could say that's a type of silence. (P1)

This outline suggests that music from the therapist that is perceived as containing little, or holds no, meaning creates an emergent space for the client. This music provides a grounding/masking function of blocking out environmental sound, focussing attention inwards to the contact between the therapist and the client. The aim is that the client will not draw meaning from and play off the music, but use it as a "silent" space to go forth in. One of the qualities P1 described was a minimisation of coercive elements that allows for client autonomy and power to still occur, "[...] I think for me to bring in that very gentle grounding type sound was almost saying, 'this is OK, this is in your own time,' rather than the abstract silence without there being any music at all". This statement makes explicit the intent of removing coercive implications from the relative silence. It suggests that some silences in music therapy can be experienced as 'expectant' or that clients may experience pressure within silence to do something. The participant suggested that the relative silence can mediate this pressure on the client. "Relative" silence, then, is a way of creating a space that is Other to the space outside of the therapy room, one that the music therapist can invite the client to be together in without demanding or coercing anything from the client.

DISCUSSION

This study, seeking to explore how music therapists understand their experiences of silence in improvisational approaches resulted in three categories developed from interviews with three music therapists. This section will explore individual experiential statements and bring them together from different categories to propose a richer concept of the functions and roles of silence.

Surviving the transition

Participants suggested that a stable therapeutic alliance (Flückiger, 2018) is foundational to feelings of togetherness between client and therapist in silence. Dauenhauer (1980) requires both participants to have psychological security to be able to enter the state of intersubjective relatedness that he and Stern (2004) describe. Dauenhauer's (1980) codiscourse and deindividualised silence parallel the silence at the end of musicking between therapist and client. The sense of intersubjective relatedness and togetherness transfers from the shared musicking between therapist and client into the silence beyond the sounds. Participants framed this continuation as an essential aspect of silence that clients needed to survive and allow therapeutic processes to begin. The transition into silence is an event that challenges the strength of the therapeutic alliance. If the therapeutic alliance is strong enough to survive this transition, then the sense of togetherness, safety, and containment remains. If the therapeutic alliance is not strong enough to withstand these initial moments of silence then it is possible that a separation between client and therapist occurs, instilling a sense of loss or isolation in both members of the dyad. In this way, silence is a trial of the dyad's relationship; one that both must be able to pass through together.

Reconstruction, reflection and self-actualisation

All participants described silence in clinical work as an opportunity to reconstruct and explore the meaning of the music that they had taken part in as well as speculating that clients found silence to be an important space to be able to process their own experiences. Potter (2017) suggests that silence invokes the listener to creatively reconstruct the performer's meaning. In these examples, both the therapist and client simultaneously occupy the positions of audience and performer, reconstructing and exploring the meaning of the other's music within the context of their own intentional performance.

Participants differentiated the way in which they believe the silent space was utilised by the therapist and clients. Participants implied that the therapist split their attention between internal (therapist focussed) and external (client focussed) anxieties in silence, whereas client attention was generally implied to be internally focussed. This mirrors Sutton's (2023) suggestion that therapists actively make space for considering how the silence evolves from the client's music making, and what the silence may mean for the client.

It was expressed that clients internalising experiences of silence from therapy sessions may be a helpful goal. This internalised silence was considered beneficial for clients in allowing them to engage in reflection and introspection. This therapeutic aim is reminiscent of the existential and humanistic goal of self-actualisation for the client (Maslow, 1954; Rogers, 1951, 1961; Yalom, 2002). Rogers (1959) posits that we want to feel and behave in ways which are consistent with our self-image. Through authentic reflection of actions and experiences, clients are able to be empowered and move closer to an ideal-self. Participants seem to consider internalised silence to be an enabler of this critical reflection and self-actualisation.

Being authentic

Participants recounted moments of silence where the intention was to enable the client to experience power and autonomy. Dauenhauer (1980) considers silence both as an active performance (an action that is chosen over all other possibilities by the individual) as well as a non-determinate (an action that allows for an infinite array of possible subsequent actions). Potter (2017) and Sutton (2006) consider the silence at the end of music as a moment of power shifting from performer to audience.

If “control” of silence can be given, received, and acted upon by the client, then an interesting concept of silence begins to form: a space that engenders client autonomy and power, which clients can authentically exist in, and in which they are empowered to define limits.

THROUGH-LINES OF MEANING

Silence is a space of uncertainty, whether it is framed as Dauenhauer’s (1980) non-determinate, or Clifton’s (1976) tension; participants reflect this in their experiences of anxiety. Both therapist and client enter a space in which the client is empowered and able to choose to end the experience. As a space for previously unexplored client material to emerge from, it is possible to consider the action of the client breaking the silence as an authentic, powerful act.

Linking the ideas discussed, it is possible to create a through-line of meaning from before the silence to afterwards:

- (1) Togetherness in musicking is transferred into the silence along with power transferred to the client.
- (2) The client and therapist continue the musical process through creative reconstruction and meaning making.
- (3) A space of empowerment and autonomy for the client is created in the silence in which they can experience a new way of being.
- (4) The intersubjective connection between client and therapist persists.
- (5) Experiences and meaning making are integrated by the client and therapist during the silence.
- (6) The silence is broken by an authentic act by the client.
- (7) After the silence the experiences of musicking and the processing of that reconstructed meaning in silence shape the actions that follow (further musicking, discussion of experiences, the client’s new understandings of situations, etc).

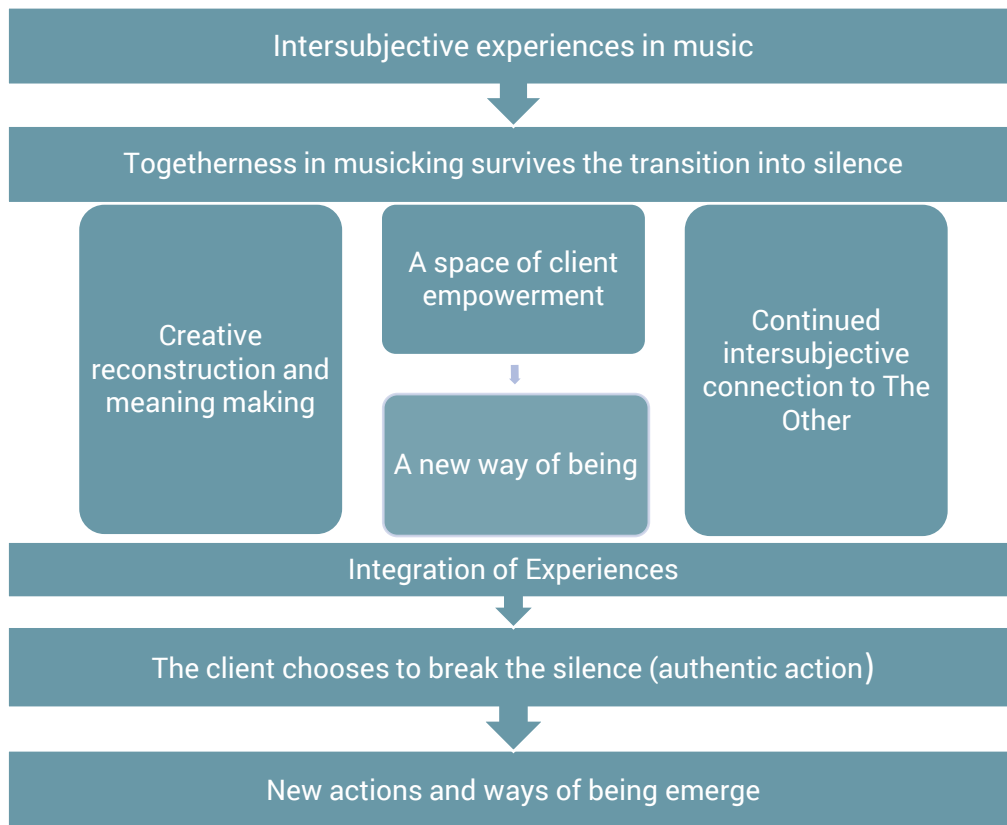


Figure 2: Through-lines of meaning concept

This chain of events is not a prescription, nor is it a static series; actions and processing may happen in different orders or concurrently. It is intended to be illustrative of how silence could be conceptualised as a space in which through-lines of meaning are maintained from one series of audible actions to the next, including silences within a single piece of music, several series of music making with silence between, or in silence after music that leads to something else. This theory reflects participants' observations that the things that happen after silence are shaped by the context of the silence experienced. Dauenhauer (1980) describes a model in which meaning is transferred from one moment to the next but is changed and contextualised with each transfer, using moments of silence to carry meaning forwards in time through processes of reflection, reconstruction and recontextualisation. Further research may provide opportunity to refine this theory, lending itself to a Grounded Theory approach; for now, it may serve as a starting point for that research and for clinicians interested in the therapeutic effects that silence may provide in session.

Limitations

The study presents the following limitations about the data gathered and the insights able to be made into the subject area. Firstly, participant clinical fields are not homogenous. There is potential for unique meaning making and ways of being for music therapists working with specific client populations that may not be represented in this study due to the breadth of client groups that the participants drew their experiences from. A more focused inquiry into the experiences of music

therapists working with X client group may provide richer and nuanced insight into specific kinds of meaning making about silence.

Secondly, the researchers and all participants identify as “White”. This leaves a gap in which unique perspectives and meaning making experiences with different cultural and ethnic groups may not be described. Exploring experiences of music therapists that do not identify as “White,” may offer richer and more heterogeneous experiences that were not described here.

Finally, the study only engages with the perceptions of therapy from the therapist’s perspective; further research into client’s perception and meaning making of silence will deepen our understanding regarding implications for clinical practice.

Implications for future research

Participants in this study described silence as having effects and enabling experiences and processes for clients. The above limitations suggest potential future research that is worth pursuing for reasons of developing specific and nuanced understandings of silence in music therapy, as well as general statements that may inform adaptations in clinical practice. Exploration into clients’ experiences of silence within music therapy that engage with the inferences presented in this study may begin developing a more complete picture, offering insight into the therapeutic and intersubjective qualities of silence.

CONCLUSION

Using participant data from semi-structured interviews with three music therapists, silence has been illustrated as a multitudinous phenomenon within therapy. Although silence can be anxiety inducing and overwhelming, it may also be a space in which powerful meaning making, experiences, and therapeutic processes can be facilitated for clients. The implications for practice are direct, framing the strength of therapeutic relationship as an antecedent to beneficial therapeutic experiences in silence. The study outlines the need for further research into how silence is conceptualised in music therapy.

Disclosure statement and participant consent

The authors report no conflict of interest. Participants have consented to participation and publication of this research.

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Κατανοώντας τις σιωπές, όχι μόνο τους ήχους: Μια διερεύνηση της νοηματοδότησης της σιωπής από μουσικοθεραπευτές στη διαδικασία της αυτοσχεδιαστικής μουσικοθεραπείας

Garrick Wareham | Luke Annesley

ΠΕΡΙΛΗΨΗ

Η σιωπή αποτελεί μια κοινή εμπειρία στη μουσικοθεραπεία, με ενδεχομένως πλούσιο νοηματικό περιεχόμενο· ωστόσο, η διαθέσιμη βιβλιογραφία σχετικά με τη σιωπή στην αυτοσχεδιαστική μουσικοθεραπεία παραμένει περιορισμένη. Το παρόν άρθρο αναδεικνύει συνδέσεις ανάμεσα στη μουσικολογική, ψυχολογική, φαινομενολογική και μουσικοθεραπευτική βιβλιογραφία που αφορούν: τυπολογίες της σιωπής, τη σιωπή ως διυποκειμενικό φαινόμενο, και τη σιωπή ως χώρο για αναστοχασμό και επεξεργασία. Η σημασία της νοηματοδότησης και της σιωπής στην αυτοσχεδιαστική μουσικοθεραπεία διερευνάται μέσα από δεδομένα ημιδομημένων συνεντεύξεων και με τη χρήση Ερμηνευτικής Φαινομενολογικής Ανάλυσης (Interpretative Phenomenological Analysis, IPA). Η ανάλυση των συνεντεύξεων μέσω της Ερμηνευτικής Φαινομενολογικής Ανάλυσης (IPA) ανέδειξε τρία υπερκείμενα θέματα, τα οποία αναπτύχθηκαν από τον κύριο συγγραφέα και ελέγχθηκαν από τον δεύτερο συγγραφέα, και τα οποία περιλαμβάνουν δέκα υποκείμενα θέματα: “Άγχος και ένταση κατά τη διάρκεια και μετά τη σιωπή”, “Η σιωπή ως χώρος” και “Κλινικές παράμετροι της σιωπής”. Γίνονται συνδέσεις ανάμεσα στην ανάλυση των συνεντεύξεων των συμμετεχόντων και στην υπάρχουσα φαινομενολογική, μουσικολογική, ψυχοθεραπευτική και μουσικοθεραπευτική βιβλιογραφία για τη σιωπή. Η συζήτηση καταλήγει ότι η αντιλαμβανόμενη ισχύς της θεραπευτικής σχέσης από τον θεραπευτή αποτελεί καθοριστικό παράγοντα για την εμπειρία της σιωπής στο θεραπευτικό πλαίσιο. Το άρθρο σκιαγραφεί επίσης τη σιωπή ως χώρο αναστοχασμού και αυτοπραγμάτωσης, καθώς και ως διευκολυντικό παράγοντα στην εμπειρία ενδυνάμωσης και αυθεντικότητας των πελατών. Επίσης, παρουσιάζεται μια θεωρία, βασισμένη στα δεδομένα των συνεντεύξεων, η οποία προσφέρει μια σκοπιά θεμελιωμένης θεωρίας. Η θεωρία αυτή προτείνει ένα μοντέλο συνέχειας και κυκλικής αναπλασίωσης του νοήματος από το μουσικό στο σιωπηλό και πέραν αυτού. Η μελέτη προσδιορίζει τις επιπτώσεις στην πρακτική και αναδεικνύει περαιτέρω ευκαιρίες για την εδραίωση της υπάρχουσας θεωρίας και την ανάπτυξη εννοιών που είναι μοναδικές για τη σιωπή στη μουσικοθεραπεία.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

αυτοσχεδιαστική μουσικοθεραπεία, σιωπή, φαινομενολογική ανάλυση, νοηματοδότηση

ARTICLE

“Becoming a shapeshifter”: Towards developing best practice guidelines for arts therapies outside of private practice in South Africa

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ABSTRACT

The arts therapies are regulated professions in South Africa. Although the Health Professions Council has produced a *scope of practice* for these professions, there are no *guidelines for best practice*. This is particularly important for practitioners working outside of private practice and in developing countries where the needs are pervasive and practice is extensive. Through six focus group discussions and two in-depth interviews with 20 arts therapists working outside of private practice, we explored how they are working (including the challenges and ethical dilemmas they encounter), how they respond to these challenges and dilemmas, what resources they use, and how they perceive their roles and responsibilities. Through gathering and analysing this data via thematic analysis, we sought to develop guidelines for best practice. We propose and discuss eight best practice guidelines for responsive and responsible arts therapies practice-in-context, discussing their rationale and application. These guidelines may be useful for all practitioners seeking to work in ways that are sensitively responsive to context.

KEYWORDS

arts therapies,
guidelines for best
practice,
community,
art therapy,
dance/movement
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INTRODUCTION

The creative arts have been intuitively used for millennia, arguably to serve an evolutionary function and adaptive purpose (Kaimal, 2019). The *arts therapies* (including art therapy, music therapy, drama therapy, and dance/movement therapy) draw from the benefits inherent in creativity, imagination, non-verbal communication and self-expression (among other mechanisms). These disciplines were formalised in countries such as the United Kingdom and the United States from the 1950s and 60s onwards, professionalising the therapeutic role of the arts in physical, rehabilitative, psychosocial and mental healthcare (Karkou & Sanderson, 2006).

In South Africa, the arts therapies professions are regulated by the Health Professions Council (HPCSA, 2022), with the South African National Arts Therapies Association (SANATA) being the professional association.¹ The HPCSA sets contextually relevant standards for healthcare training and practice and maintains the country's ethical and professional practice standards. Although the HPCSA has produced a *scope of practice* for the profession, there are no *guidelines for best practice*, particularly for practitioners working outside of private practice where the scope is broad, the needs pervasive, and practice is extensive. South Africa is also a highly diverse society (Chaka & Adanlawo, 2023) requiring flexible approaches to practice.

There are formidable healthcare challenges in South Africa that include colliding epidemics that are often comorbid or syndemic: HIV and tuberculosis, chronic illness and mental health, injury and violence, and maternal, neonatal and child health (de Villiers, 2021; Mayosi et al., 2012; Shisana et al., 2024). In this context, these epidemics are significantly driven by social determinants such as poverty, lack of access to quality education, healthcare and social protection, and unemployment (Ataguba et al., 2015; Egede et al., 2024; Jemiluyi & Jeke, 2024; Mbazima et al., 2024), leading to great inequality and requiring a social justice lens to healthcare delivery and intervention (Gopalakrishna, 2022; Meyer, 2014; Swartz, 2022). The national public health sector, staffed by around 30% of the country's doctors, remains the exclusive healthcare provider for more than 40 million uninsured people, constituting around 84% of the national population (Mayosi & Benatar, 2014; Ngobeni et al., 2020).

The prevalence of mental disorders in South Africa is high. In the only extensive epidemiological study of mental health, 16.5% of adults reported a common mental disorder in the past year (Williams et al., 2008). Yet, only 1 in 4 participants had treatment of any kind during this time (Seedat et al., 2008). The prevalence of mental health problems in children and adolescents in sub-Saharan Africa is estimated at 14% (Cortina et al., 2012), and the treatment gap is larger than adults at around 90% (Saade et al., 2023); child and adolescent mental health is severely underserved. Access to mental health services in public healthcare in South Africa is marginal, mainly on account of poor recognition and screening of mental health problems, stigma, and lack of resources, with 0.28 per 100 000 population psychiatrists, 0.32 psychologists and 0.40 social workers (Janse van Rensburg et al., 2022; Lund et al., 2010). In South Africa, arts therapists are lobbying to obtain public healthcare positions, but these are still unavailable to the profession. This is a missed opportunity as there is great potential to utilise the profession with such skills shortage and need.

¹ Their definition of each modality can be found at <https://sanata.org/art-therapies/>

As a result of the inability of the public healthcare system to meet the needs related to pervasive mental health problems (Coovadia et al., 2009; De Kock & Pillay, 2018), these are typically served outside of public healthcare. Many arts therapists work in private practice, educational settings, non-profit organisations (NPOs), or non-governmental organisations (NGOs). This sector (NPO/NGO) has a rich political history in South Africa and has played a significant role in shaping and transforming service delivery when the state has not, or when health and welfare have been inadequate or inequitable (Choto et al., 2020; Parekh, 1997; Pillay, 2022). Currently, this sector manages a mental healthcare gap in service delivery that is largely donor-funded (Ayinkamiye & Spencer, 2021), a reality that can lead to conflicts of interest (Claeyé & Jackson, 2012) and challenges with sustainability (Harding, 2014). The sector is vibrant and diverse, leading to innovative interventions and creative responses to mental health needs; however, it is also poorly regulated and may benefit from more coordination with state and other services delivering care to the public (Choto et al., 2020; Moshabela et al., 2013).

In low and middle-income countries (LMICs), like South Africa, where the arts therapies professions are relatively new (33 years in South Africa, with 110 practitioners registered with the HPCSA at the time of this study), and where local clinical research is relatively scarce, local practitioners are a vital source of social capital and can help shape best practice guidelines. To capitalise on local knowledge, we invited registered arts therapists to focus group discussions to elaborate on how they navigate their clinical work outside private practice. (In a separate, related paper; dos Santos et al., 2025) we report on findings from a scoping review that examines studies published on this topic.) Our research questions for the current study were as follows:

1. How are arts therapists (ATs) working outside of private practice in South Africa?
 - 1.1 What challenges do they encounter?
 - 1.2 What ethical dilemmas do they face?
 - 1.3 How do they respond to these challenges and dilemmas (and why do they respond to them in these ways)?
 - 1.4 What resources do they use, and how do they use them?
 - 1.5 How do they perceive their role(s)?
 - 1.6 How do they perceive and engage with their responsibilities?
 - 1.7 What do these ATs need to sustain their work?
2. What do we learn from this that can inform guidelines for best practice in these contexts?

METHODS

Research process

We invited arts therapists in South Africa who work outside of private practice to participate in focus groups. (We also conducted two individual interviews with participants who could not attend any of the focus groups.) Through thematic analysis, we generated themes and used these as a foundation to propose guidelines for best practice.

Participants

A list of all registered arts therapists was sought from the HPCSA (hpcsa.co.za), which yielded 110 practitioners. As part of this community of practitioners, we had all these arts therapists' contact information. We purposively selected practitioners who were recently registered and newer to the field (registering within the last five years), as well as those with more experience. We sampled practitioners from all the arts therapies, including art, music, drama, and dance/movement therapists. We tried to sample participants who identify as men for this investigation as there were only four registered; all other practitioners identify as women as far as we were aware. As the community of arts therapists is relatively small in South Africa, we have a good understanding of where practitioners were working, and we invited all those we were aware of who have worked outside of private practice contexts from a range of provinces across the country. Participants were invited via email to participate in a focus group discussion (FGDs) and were given information about the study. We offered various options for times of FGDs and participants chose which one suited them best. Forty-one practitioners were invited to participate, and n=20 signed up (5=art therapists; 9=music therapists; 5=drama therapists; n=1 dance/movement therapists) to participate in six FGDs and two individual interviews.

Positionality

All three researchers are white South Africans who identify as women. We are registered arts therapists (two are music therapists and one is an art therapist) with approximately 20 years of clinical practice experience each. The majority of this clinical work has been based in community practice. We are researchers (two have PhDs and one is currently undertaking a PhD) with over 20 years of experience conducting qualitative research, and we are educators at two South African universities that train arts therapists. In addition, we serve as both research and clinical supervisors to graduate students in arts therapies. We all have multiple roles and serve in various positions within the arts therapy community in South Africa, enabling a degree of insight into the profession. This subjectivity also comes with limitations that need to be critically examined and will be discussed in the section below on reflexivity.

Ethical considerations

All participants gave written informed consent for FGD participation and audio recording on the Zoom platform. Ethical clearance was granted by the University of Pretoria's Faculty of Humanities Research Ethics Committee (HUM014/0823). At the start of each FGD, facilitators reminded participants of their shared commitment to confidentiality and encouraged them to uphold it. This was an important ethical consideration given that many participants were known to each other. Pseudonyms were used, and no identifying information was included. Participants were free to withdraw at any time.

Data collection

Each FGD took approximately 90 minutes. The questions posed in the FGDs mirrored the research questions guiding the study. The FGD guide was piloted with the three researchers. The two researchers who served as facilitators of the FGDs with arts therapists attended the pilot as participants, and the third researcher facilitated the discussion. This pilot FGD was audio recorded, transcribed, and analysed by the pilot facilitator. We discuss this process further below.

Two researchers facilitated three FGDs each. Facilitators tried, where possible, to conduct FGDs with participants who were not known or less well-known to them. While we elected to conduct focus groups so that participants could discuss the issues raised with one another in the group (potentially stimulating additional/deeper insights), one researcher conducted two in-depth interviews with participants who became unavailable for the scheduled FGDs they signed up for. All participants identified as women, and only one was non-white (there is little racial diversity in our sample and generally in the field in South Africa with only n=8 practitioners who were non-white and registered with HPCSA at the time of this study). Data collection occurred from October 2023 to February 2024.

Reflexivity

Before recruiting participants and facilitating FGDs, we engaged in a pilot focus group as researchers. This allowed us to take the questions for a “test drive,” but crucially, it facilitated exploring and articulating our experiences, assumptions, motivations and concerns related to arts therapies practice outside of private practice contexts in South Africa before gathering and analysing data from other practitioners. Reflexivity can be greatly enhanced by working in a team (Barry et al., 1999). Whilst researchers often simply write a paragraph reflexively presenting their positioning, experience and motivations, because we fully thematically analysed our views expressed in our focus group, we present these in Table 1.

As we proceeded to recruit participants, conduct the focus groups and organise and interpret participants' insights, we could clearly and transparently hold our own perspectives in mind, critique them, use them when appropriate, and set them aside if they were challenged. We see reflexivity as a process through which researchers acknowledge that they are active role players in meaning-making within their studies (Alvesson & Sköldberg, 2000; Etherington, 2004; Stige et al., 2009). The variant of reflexivity that we subscribed to in this study held the balance between seeking to allow the phenomenon to reveal itself as far as possible whilst acknowledging that we cannot ever fully step outside of our perspectives. We can work to recognise these and present them with transparency. We also note that the constructs we use through our questions, theme development and discussion of findings actively shape meaning as well.

Professional experience

Characteristics of the contexts

- Work outside of private practice typically occurs in informal contexts [Formal contexts=resourced (on all levels) vs Informal=lack of resources; lack of referral systems]
- Perception of the arts therapies is fluid in informal contexts
- There are challenges and opportunities
- Collapsing health care system

Challenges of working in these contexts

- Lack of mental health understanding
- Emotionally taxing
- Difficulties managing boundaries
- The latent trauma within systems can be challenging for professional relationships
- Specific ethical dilemmas in under-resourced settings
- Lack of suitable referrals
- Knowing that even with referral, patients won't receive the care they need
- Unreliable care within health systems
- Basic human rights not being met
- Addressing needs vs staying inside scope of practice
- Sustainability questions related to going over and above for service-user care

Motivation for working in these contexts

- Political motivation; committed to social justice
- Arts are accessible and already a resource
- The arts therapists' personality fits well with the demands of the work

Roles and responsibilities

- Managing, supervising, training
- Advocating for social change
- Advocating for alternative ways of approaching mental health
- Addressing systemic, not just individual, issues
- Working with resources and people who are already there
- Always considering sustainability
- Critically reflecting on one's role
- Building and working within networks

Training and supervision

- Lack of training on how to build networks
- Critical reflexivity training is valuable
- Becoming well-informed so you can go into the work with your eyes wide open

Research

- Unique arts therapies skills and insights contribute to large multidisciplinary studies

Being a supervisor

- Supervisors should have work experience in similar contexts
- Supervisors should have broad knowledge, not only clinical skills (e.g., including how to network; roles in multidisciplinary teams)

Best practice**Defining “best practice guidelines”**

- Guidelines for “Good enough” practice – potentially more realistic
- Best practice = well-informed practice

Guidelines

- We should work to stay true to what our professions uniquely offer
- Be flexible and adaptable
- Expect the unexpected
- Use a strengths-based, resource-oriented approach
- Recognise social and structural drivers of mental health struggles
- The work should be sustainable
- Grit is important (and to be aware of when you don't have the necessary grit)
- Participants should hold ownership and have agency
- We need to have a collaborative stance
- Accountability is non-negotiable
- You cannot work in isolation; you need a team
- Get advice from others who are navigating this collapsing healthcare system
- Relevant supervision is essential
- Within the systems you work in, use the negotiating power that you do have
- Make use of continuing education opportunities
- Use relevant theoretical frames and research
- Constantly thinking about ethics & how to navigate the complexity of ethical dilemmas in these contexts
- Self-care

Table 1: The researchers' positions and insights on the topic under investigation**Data analysis**

All FGDs with participants were audio recorded on Zoom and transcribed using MeetGeek (meetgeek.ai) (which has end-to-end encryption; data cannot be accessed by third parties). Transcriptions were checked for accuracy by the researcher who facilitated the FGD. Initial broad codes were collaboratively developed between all the authors based on the review of literature, the topics in the questions in the focus group guide and an initial full reading of all the transcriptions (Creswell, 2014). This is a well-established approach for qualitative analysis (Oliveira, 2023; Richards & Hemphill, 2018), especially in collaborative analysis as was the case in this study. The research team began by analysing the same transcript using this codebook, and codes were further refined through an inductive analytic approach, as our goal was to ensure that meaning was derived from the data rather than assuming preset viewpoints (Miles et al., 2020). The team then met again to discuss and revise the codebook before coding the entire dataset. Transcripts of the six focus groups and two individual interviews were thematically and double-coded by two researchers (i.e., thematic codes were applied to each transcript by each researcher). The research team critiqued the findings to reach an agreement on the findings and optimise insights.

FINDINGS

This section presents our analysis of FGD and interview data (Table 2). Participants shared insights on strategies, resources, and approaches for navigating challenges and sustaining practice outside private practice. A key limitation was inadequate representation of a more diverse sample, particularly around gender and race. This is particularly important in the South African context, where most service users in communities are people of colour and where the views of practitioners of colour would have been significant.

We explore participants' descriptions of context, practice characteristics, and their motivations for working in these often challenging environments. These specific themes were selected for their relevance in defining the scope of arts therapy practice outside of private practice and providing contextual background for the proposed best practice guidelines presented in the discussion section.

Integrating insights from focus group discussions and interviews

Table 2 presents our organisation of the themes and subthemes in response to the research questions.

A South African context of complex needs

Participants' descriptions of the contexts in which they work highlighted the multilayered needs of the majority of people living in South Africa, perpetuated by deeply entrenched systemic drivers of inequality and poverty. In discussing work within an in-patient unit, Emma described how inadequate social service interventions and unsafe community environments exacerbate children's mental health needs:

[Social workers] only take the worst of the worst [and] kids fall through the cracks. Their mental health has just completely deteriorated because of the environment they have been living in. So that's very difficult...knowing my limits and my scope within a space like that...knowing that, ultimately when they get discharged, they're probably going back into quite a toxic system. So I find that challenging but also really rewarding to see what music therapy can offer kids like that: what a difference it can make.

This context requires assessment at individual and community levels, while considering systemic drivers, with practitioners adapting conventional clinical approaches to remain responsive to multi-level needs.

Professional experience

Characteristics of the contexts

- Complexity of needs:
 - Complex, multi-layered needs of service users (mental health, food, housing, trauma, grief, disability)
 - Widespread intergenerational trauma and grief
 - Limited access to care/support resources
 - Dysfunctional health and care systems exacerbating mental health issues

Characteristics of arts therapy practice

- Service-users:
 - Work with individuals from prenatal to advanced age.
 - Address acute, chronic health, mental health challenges, and socio-economic issues.
 - Includes vulnerable groups and caregivers
- Settings:
 - Disability, education, public health, and social development sectors.
 - Both formal (schools, hospitals, care facilities) and informal settings (NPO, community-based projects)
 - Settings often lack adequate resources
- Scope of arts therapy interventions:
 - Level of intervention ranges from individual, family, organisational to community level.
 - Focus areas include: mental health; educational support; social justice issues; psychoeducation; skills development, training and capacity building; wellness and self-care
 - Format both online and in-person; group and individual arts therapy, with emphasis on group work; support groups; skills development and training workshops; performances
 - Interventions occur across the continuum of care (prevention/health promotion/early detection ⇒ treatment/clinical therapeutic services ⇒ continuing care/recovery/ongoing support)
- Nature of employment:
 - Full-time, part-time, and project-based positions, either paid or pro-bono.
 - Predominantly in non-profit organisations, with limited paid roles in public hospitals.

Roles and responsibilities

- Multiple, varied roles
- Time-consuming organisational duties (e.g., fundraising and networking)
- Shifting roles due to evolving needs
- Advocacy for arts therapy and social justice

Motivation for work

- Systemic/ecological approach resonates
- Work offers diversity, novelty, and independence
- Motivated by idealism and desire to make a difference
- Commitment to social justice
- Suited to pioneering and avant-garde personalities

Challenges of the work

- Service-users' needs often exceed therapists' scope, leading to burnout
- Unpredictable nature of the work is draining; requires more capacity and resourcefulness than arts therapists may possess
- In contexts of overwhelming community needs, therapists' self-care is neglected.
- Identity of therapist (white/privileged/educated) can undermine the work
- Requires ongoing advocacy for arts therapies' role, efficacy
- Unclear role boundaries
- Arts therapy practice is impacted by level of community and organisational buy-in
- Financial-resource competition in under-resourced settings
- Chaos and instability in community context spill into organisational/institutional setting (parallel processes)
- Sustainability depends on unstable funding
- Profession's emerging status subjects practitioners to heightened scrutiny and necessitates the highest ethical standards

Specific ethical dilemmas

- Complicated notions of harm and safety in context of pervasive unmet psychosocial needs
- Inadequate referral systems
- Systemic injustice complicates ethical decisions
- The arts' evocative potential brings unmet mental health needs to the surface in unsupported contexts
- Access to supervision and personal therapy for arts therapists is difficult and expensive.
- Confidentiality and consent issues
- Blurry line between skills-sharing and therapy
- Difficult decisions on resource allocation in high-need contexts

Strategies for navigating challenges

- Ecological thinking, trauma informed, systemic and strengths-based approaches.
- Intentional identification, access, mobilisation and maintenance of resources
- Flexible and adaptive practices
- Cultural sensitivity and humility
- Consider sustainability in all aspects of practice
- Collaborative approach
- Intentionally cultivate a community of practice through collaborative relationships within the broader community
- Responsibility for establishing and maintaining active referral networks lies with the arts therapist
- Organisational sustainability requires skilled leadership, supportive structures, reflexivity, and expanded responsibilities beyond traditional roles
- Mediating funders' expectations with community needs and rights
- Roles and responsibilities in complex contexts requires diverse skills, clear boundaries, and adaptability while navigating unpredictable environments
- Slow, measured practice approach
- Manage own capacity and self-care

Strategies for navigating ethical dilemmas:

- Consider potential harm in resource-limited contexts
- Consider safety through a social justice and resource-oriented lens
- A situated, fluid consideration of safety: "as safe as possible" within unsafe spaces
- Conventional notions of therapeutic boundaries requires reframing
- Boundaries informed by care continuum position
- Educate stakeholders on ethical standards
- Manage expectations, provide debriefing, and establish referral networks when providing skills-sharing/training

Training and supervision

Challenges related to training

- “I don’t know how one prepares anybody to really know how to deal with just so much need” (Camila)
- Western-based knowledge may not fit the South African context
- Overseas training may not be adequate for local complexities

Helpful resources and approaches

- Networking, collaborative practice, relationship-building skills
- Diverse internship placement experience
- Diverse trainer profile
- Attitude of ongoing learning
- Eclectic theory integration
- Relevant theories:
 - Systemic and relational theories: systems theory; family constellation theory; group theory; gestalt theory
 - Individual-focused theories: humanistic perspective; positive psychology; psychodynamic theory (attachment; Bion’s theory of containment)
 - Sociocultural and critical theories: theories from anthropology and sociology; feminist theory (Black feminist theory; Afro-feminism)
 - Community development theory: Asset-based community development
 - Trauma-focused theories: trauma-informed theory; intergenerational trauma; socio-ecological resilience
 - Applied theoretical approaches: training in psychological first aid

Supervision

- Essential for ethical practice and support
- Often costly and limited access
- Supervisor need experience in working in contexts of complex needs to support adaptive practice and ethical decision-making

Research

- Challenges: Difficult to access published research; lack of confidence and resources (time, funding) for research investment
- Ethical research practice is collaborative, transdisciplinary, inclusive, transparent, considers power dynamics
- Strategies for increased SA-based research:
 - Support from academic institutions and peer groups
 - Funding
 - Collaborative research spaces
 - Research embedded in training and practice to guide advocacy and professional growth

Table 2: Themes and subthemes

Characteristics of arts therapy practice in contexts of complex needs

Arts therapists work across the lifespan with diverse groups including those with health challenges, vulnerable groups (children and youth in social care, refugees, migrants, victims of xenophobia and gender-based violence, women in prison, people facing socio-economic challenges (poverty, housing

and food insecurity), caregivers and professionals in helping roles (educators, first responders, police, social workers).

Arts therapy practices span public sectors (disability, education, health, social protection, and social welfare), operating in formal state-regulated institutions and—more commonly—within regulated NPOs and informal (i.e., unregistered and unregulated) grassroots organisations or community-based projects. Therapists' feelings of overwhelm can be limited by lack of oversight in informal settings, the positioning of arts therapies as an isolated mental health service within a context of complex and multilayered psychosocial needs, and challenges related to practice boundaries.

Work ranges from full-time, part-time, and project-based work, primarily in NPOs and grassroots organisations, with some voluntary or grant-funded positions in state institutions. Resource constraints affect both sectors, limiting funding, access to complementary psychosocial support services, and referral networks.

Under-resourced settings require arts therapists to assume multiple roles and responsibilities, ranging from leadership and strategic to administrative and operational, alongside their therapeutic work. The volatility of these contexts causes roles and responsibilities to constantly shift to remain responsive to the dynamic nature of community needs.

In light of the lack of formal integration of arts therapies in public health care services, participants highlighted their responsibility to advocate for the scope, value and efficacy of arts therapies. Alongside advocacy for arts therapies within existing structures and systems, therapists also play an advocacy role in the social justice issues relevant to the community they work in. Anna described this advocacy role in addition to other responsibilities, some outside her skillset:

We began women's workshops linked with menstrual health. We've partnered with organisations who fight period poverty...[A]ll the roles as a practitioner and the director, administrator and finance person, which is absolutely the worst role ever for me. And then it's all linked with activism and advocacy all the time as well.

The landscape of arts therapies beyond private practice is expansive, and practices are sustained despite the myriad challenges practitioners, service users, and their communities face. Therapists' commitment to these complex contexts reveals unique motivational drivers that underscore both the potential and challenges of arts therapies.

Arts therapists' motivation for working in contexts of complex needs

The motivations for working in these contexts seem to align with therapists' individual dispositions and theoretical orientations. A systemic perspective resonated with some participants. As Abigail stated, "I don't believe in private practice, I don't believe in this individualistic health model." Similarly, Lily described how her perspective expanded through community development theory.

The opportunity to work in uncharted territory—within settings, institutions and organisations unfamiliar with arts therapies—inspired some participants, who found the diversity and novelty of the work stimulating. The demand for innovation seemed to align with the intrinsic qualities of some participants, who intentionally chose to engage in practices that required them to be innovators:

In any other context outside South Africa...[they] are so regulated... so careful... so rule-driven. I feel like as South Africans—maybe this will change as well—but while I've been working, it's like no one cares what I do, and it's kind of the cowboy, like the kind of pioneer. You can kind of create the space; you can make the field as it's happening. (Abigail)

Therapists' commitment to social justice was another key motivator, which aligns with socio-ecological arts therapy approaches. However, Abigail also cautioned against an over-idealistic notion of the role of arts therapies in the pursuit of social change, highlighting the importance of reflexivity and continuous engagement with one's personal motivation.

DISCUSSION

Figure 1 presents themes and the proposed best practice guidelines. We start this section by exploring a socio-ecological consideration of health and the continuum of care as an overarching framework for considering arts therapy practice in contexts of complex needs. We then present eight proposed best practice guidelines grounded in participants' data. While quotes from participants are typically included in a findings section and not in the discussion, we have elected to include them here to show how the guidelines extend from the findings and remain grounded in the data.

A socio-ecological consideration of health and the continuum of care

A socio-ecological approach to health and well-being considers the determinants of health from an integrated physical, social and economic perspective at both individual and societal levels. From this perspective, the continuum of care refers to “a seamless and coordinated course of multi-faceted actions...It ensures that actions meet populations ‘where they are’ on the continuum of health, whether that be to maintain health, reduce vulnerability, reduce harms, or promote recovery” (Stephen & Walzer, 2023, p. 5). This approach considers both upstream factors—the physical, social, and economic determinants of health—as well as downstream elements, such as how the service integrates with and impacts other services to collectively support health and wellbeing for individuals, communities, and society at large. Considering arts therapy practice along the continuum of care has significant implications for practice. Private practice arts therapy services typically focus on treatment/clinical therapeutic services with parameters prescribed by medical insurance companies, dictating service-user access (limited to a prescribed list of mental health diagnoses), the level of intervention (limited mostly to the individual level, while it might include families), the format of sessions (limited to individual or small group work), and the length of treatment (limited to a predetermined number of sessions). Our analysis of the data indicates that

arts therapy work outside of private practice seems to span the entire care continuum, with interventions often focused on prevention/health promotion and continuing care/ongoing support. Participants described wide-ranging practices in terms of level of intervention, focus areas and process formats.

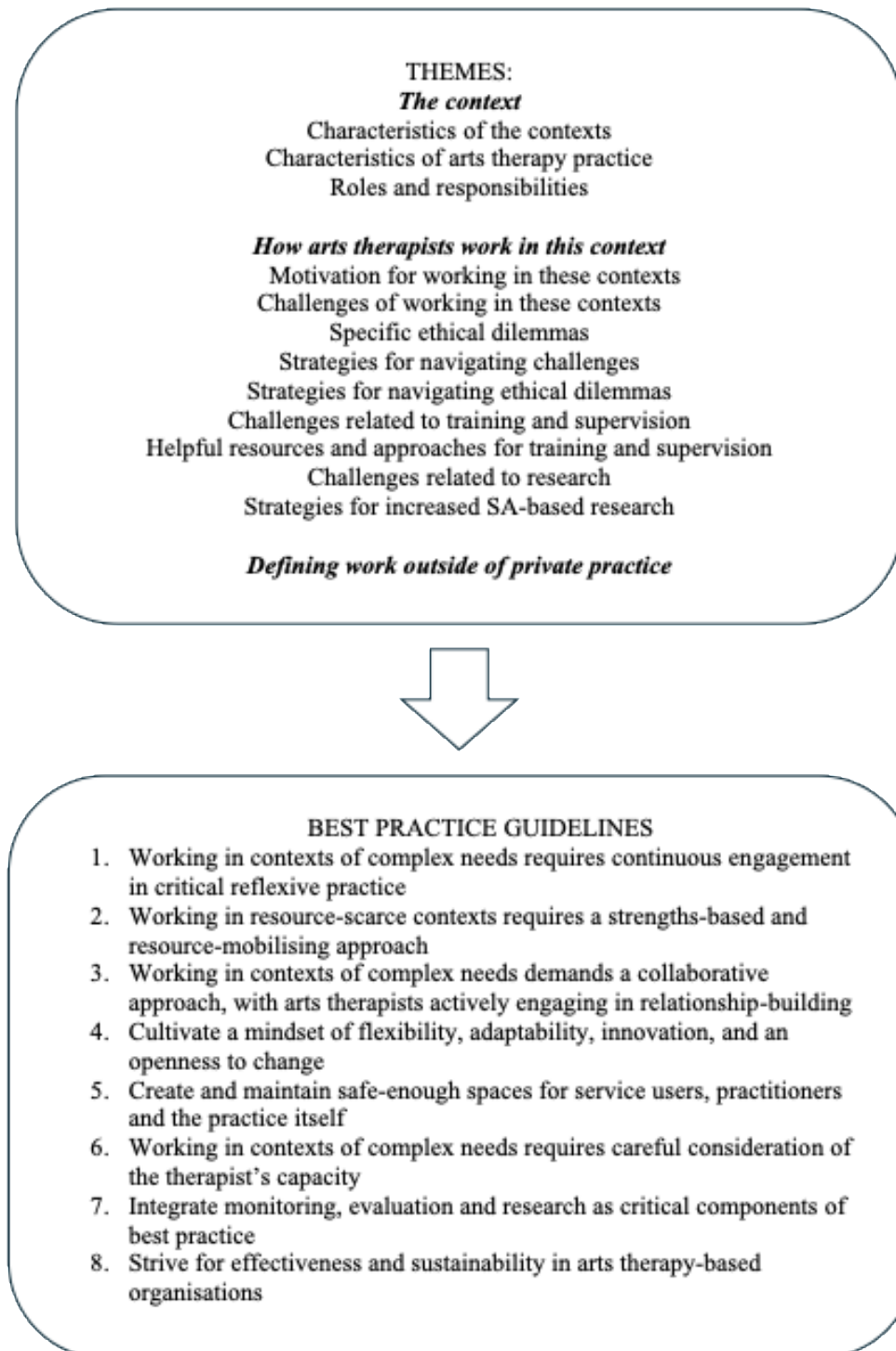


Figure 1: Themes and proposed best practice guidelines

The level of intervention in community-based settings can range from individual, family, organisational to community level. As Grace described, “The work is so contextual. It’s not just my...contact with the clients, it’s really the context that’s my client.” Services extend beyond the conventional format of individual and small group therapy sessions to include support groups, workshops and performances. Similarly, the focus areas of the work move beyond individual mental health outcomes to include educational support, psychoeducation, skills development, training, capacity building, addressing of social justice issues, wellness and self-care. For example, Evelyn described a project in a school where she worked collaboratively with community arts facilitators:

We’d have our set sessions [with children], but we were so tuned into what was going on in the whole school that when something would happen, [when] it would become a bit of a crisis, somehow we would be involved and we would be offering support. Our community musicians were really spearheading that element as well. We’d work a lot with the teachers, and we’d always be thinking about the teachers, almost more than the kids we were working with.

This socio-ecological framing enables therapists to consider the macro-context while understanding how their micro-interventions can potentially influence other parts of the system. Evelyn described the ability to “zoom in and go into the micro level and like what seeds are you planting? What little gift are you giving in that idea of exchange? And it doesn’t have to be big, massive, groundbreaking.” Camila pointed to the connections and interdependence between parts of the socio-ecological system: “When we work with a system, we tweak one part and the system can be impacted.”

While general conceptions of a continuum of care framework emphasise the coordination of services within a health care system (Heine & Hanekom, 2023; Stephen & Walzer, 2023), arts therapies lack formal integration within health and social care systems, meaning that positioning within the care continuum depends more on individual therapist’s approaches than systemic coordination. Nevertheless, the data points to the valuable role arts therapies could play in expanding services across the care continuum if formally integrated into health, education and social care systems.

Best practice guidelines for responsive and responsible arts therapy practice-in-context

The proposed best practice guidelines are informed by analysis of the data (Tables 2). Through engagement with the data, we have questioned the notion of prescriptive “best practice guidelines.” We recognise the complexity of determining “what is best” in these intricate contexts. Underpinned by participants’ shared experiences, we position these guidelines as wayfinders for arts therapists. They aim to guide practitioners in serving people responsively and responsibly while protecting and sustaining their own capacity to work within these contexts.

Guideline 1: Working in contexts of complex needs requires continuous engagement in critical reflexive practice

For therapy to be reflexive, the therapist must continuously and intentionally bring into awareness, evaluate, and modify their work through self-inquiry and collaboration (Bruscia, 2014). For example, Abigail asked, “Is there harm being done when you don’t do enough?...With the arts...you can’t limit what’s going to arise. Our very medium is kind of evocative, especially when there is that level of hunger or desperate urgency to actually be heard, to be acknowledged.” The unmet needs at a community level demand heightened self-awareness, reflexivity and robust coping mechanisms for the therapist to maintain their effectiveness.

Ella emphasised the need for reflexivity as she discussed arts therapists relocating to South Africa after training in high-income contexts: “What we find most...is the absence of being able to locate oneself here self-reflexively,...to understand the complex ethical landscape of working in mostly trauma-based work in our context.” Reflexivity includes awareness of therapists’ intersecting identities and positionality within the broader South African context.

Critical reflexive practice requires, firstly, heightened self-awareness. This demands ongoing engagement with one’s therapist identity, motivation, and limitations. The following questions can guide ongoing self-reflection: *What motivates me to do this work? Who am I, and am I the right person for this work? What are my limits? How am I keeping myself accountable?*

Secondly, critical reflexive practice requires cultural sensitivity and humility, as well as openness towards the people and place in which the work is situated. A keen sense of curiosity allows continuous engagement with and learning from and about the context. A stance of cultural sensitivity and humility requires that we approach the community for clinical and research investment before implementation. This allows us to gain a deep understanding of the community’s needs and priorities, enabling us to shape our practice in alignment with what is considered most valuable. Speaking as an arts therapy researcher, Louise highlights how this enables more equitable engagement:

A lot of the people that I’m working with do not share my cultural or ethnic background and [I have] to be very careful about benevolence, which is why I’m a pragmatist. I used action research, which is co-design and collaboration, that we are equal partners in this discovery....It fitted much better than me coming in as the expert music therapist telling you what you must do.

Practising in culturally sensitive ways requires an ability for deep listening (Pavlicevic & Impey, 2013) or “listening in all sorts of ways” as Abigail described: “That’s kind of our biggest skill that we have as arts therapists, and that’s the thing that we need to keep sharpest, and that’s what helps us practice best.”

Thirdly, arts therapists are required to reflexively navigate organisational dynamics. Abigail reflected on how parallel processes within organisations underscore another factor impacting the therapist’s role:

For example, in an addictions unit, there will be addiction in the system and then a lot of stuff gets acted out in the staff team that is parallel to the client's team. In governmental sectors there will often be things around scarcity. Each institution has its own culture that is based on the clients that they're serving, that is mirroring the clients that they're serving... So you get pulled into the dynamic so that you don't expose the dynamic or so that you don't challenge the dynamic. You often are very conflicted around well, this is what I understood my job to be, but I'm being recruited in all these other ways. That's where the blurring comes.

Understanding and navigating these complex organisational dynamics is crucial for maintaining clear boundaries and effective communication. Reflexive practice and supervision are essential tools for therapists to navigate the complex processes within organisational systems.

Reflexivity allows for the knowledge gained to inform the practice. We need to explore questions such as: *What kind of work is most helpful in this space and what should my role be in this kind of work?* Participants such as Emily emphasised the importance of having to "(lay) the groundwork and the boundaries" before the work starts. In informal spaces unfamiliar with arts therapies, clarity around purpose, scope, and boundaries is crucial for creating fertile possibilities.

Guideline 2: Working in resource-scarce contexts requires a strengths-based and resource-mobilising approach

Work in community-based contexts often involves engaging with marginalised and disenfranchised service user groups with limited and inadequate resources to meet their basic needs. Consequently, people experience a sense of disempowerment, feeling they have little choice or control over improving their circumstances (Campbell & Cornish, 2012). Camila explained how reclaiming a sense of agency becomes an imperative focus of an arts therapies process.

A strengths-based approach prioritises and leverages inherent strengths, skills, and resources of service users and focuses on empowering individuals to actively participate in decision-making processes that affect their lives (Ottemiller & Awais, 2016). Arts therapies create an aesthetic framework grounded in the socio-cultural context, from which a service user can explore and reflect on their experience (Sajani et al., 2020). Active engagement in the arts enables the inherent capacity for creativity to emerge and for resources to expand. Camilla explained:

The inherent capacity of human beings to engage in creative acts, whether of body expression or vocal expression or visual expression, is a really important framing because it enables us to approach the people that we're working with, not from seeing them as only damaged and disempowered, but actually as having a resource that we are supporting them to access.

Working in resource-scarce contexts requires identifying and mobilising resources with careful consideration of resource allocation. Resources are not limited to service users' internal strengths, skills and capacities, but include awareness, activation and mobilisation of resources in the service user's environment. Emily described how she identified resources in practical ways:

“There are instruments there but they’re mostly broken. So I found out that there’s one man at the one institution that can fix things. So I’ve started handing him things.” Anna described how their arts therapy project used community mapping to identify both the risks and resources in the service users’ community. Working within resource-scarce contexts also requires strategic management of available resources.

Decisions regarding resource allocation demand reflexivity, as they pose ethical dilemmas about who benefits from them. Confronting the reality of how unsupportive and under-resourced systems can jeopardise interventions, often at the expense of the most vulnerable, can be profoundly frustrating. Nevertheless, engaging with these questions remains critical, as responsible resource management becomes integral to therapy. Evelyn highlighted how these challenging decisions also relate to the therapist’s capacity to sustain their work:

Of course you have your ideal picture, but that depends on the money, and it’s quite a cruel thing almost to have to do, is to choose... You’ve also got to keep yourself sane because if you are burnt out and if you’re in an environment where it’s not working, you’re not going to be fully present and doing the work the way you know you can.

Guideline 3: Working in contexts of complex needs demands a collaborative approach, with arts therapists actively engaging in relationship-building

Participants described how working in dysfunctional care systems can lead to emotional strain among service users, their communities, care providers, and arts therapists alike. Evelyn noted the feelings of “hopelessness and helplessness”. Chloe reflected by asking, “When is it enough? And I don’t know if it ever felt like it was.” This underscored the pervasive sense of despondency that can increase the risk of burnout.

Socio-ecological practice, with a strengths-based and resource-mobilising approach requires intentionally identifying relational resources available in a setting to sustain service users and arts therapists alike. Ebersöhn’s (2012) research, based in South African schools in resource-scarce environments, proposed that systems can alleviate the effects of persistent stress by leveraging relationships and existing resources to foster an environment conducive to thriving. Her findings suggest that individuals facing ongoing adversity exhibit a “flock” response, wherein they collaboratively engage in a process of solidarity to access, mobilise, and sustain resources as a counter to continuous risk. Her model of Relationship-Resourced Resilience posits that individuals with access to resourced relationships are better equipped to mitigate risks associated with resource-scarce environments (Ebersöhn, 2019).

Arts therapists need to build collaborative relationships with community stakeholders and care practitioners. Isabella expressed: “An ethical practitioner is one who is in intentional community. So, held, connected, not in isolation.” The purpose of these engagements is to gain insight into the situated needs and challenges of service users and their community, build referral systems, raise awareness, and advocate for the role of arts therapy as a psychosocial or mental health service. Arts therapists can take an active role in seeking out and nurturing resourced relationships (Ebersöhn, 2019) that bring together a range of skills and supports to collectively assist service-

users. Emma reflected upon the importance of understanding and working with reliable professional support: “That helps a lot, especially in the tougher spaces. Knowing who’s there to hold and who’s there when I’m not there and what they do”. A collaborative approach challenges conventional notions of a mental health practitioner or arts therapist as an “expert” and instead promotes equality by valuing the knowledge and contributions of all stakeholders involved (Bolger et al., 2018). Anna pointed to the reciprocity of these collaborative relationships:

The community of like-minded people don't have to be people that do the same as you, but at least have the same value system or work in the same way. Or can add to you, that you can skill-share, a community of practice.

This extends to holding existing community and government support systems accountable. The arts therapist assumes a social activist role, insisting that stakeholders within these systems fulfil their mandated requirements. At the same time, collaborative relationships and supportive networks serve to keep the therapist accountable.

Clear and effective communication with organisations/institutions is essential. The current emergent phase of arts therapies in South Africa presents unique challenges for practitioners. Often pioneering their roles within organisations, arts therapists face the dual task of defining their services while navigating under-resourced environments that demand multifaceted responsibilities. This can lead to role ambiguity and place undue strain on the therapist. As Ella noted: “There are boundaries that we need to put in place that perhaps you wouldn’t have to in other spaces.” In settings unfamiliar with arts therapies, practitioners must proactively negotiate and clarify their roles and scope of practice. Emma highlighted the importance of communicating the ways in which the organisation needs to support the practice: “Before I start working, (I) try to communicate as much as possible what I do and what I need from the system in order to be able to do what I do.”

Guideline 4: Cultivate a mindset of flexibility, adaptability, innovation, and an openness to change

Complex problems require nuanced, responsive solutions. Importing conventional practices and interventions, often developed in Eurocentric contexts, might not adequately address the needs of service users in South African (and other developing) contexts. The dynamic nature of the context, coupled with the diverse needs of South Africa’s heterogeneous population, requires an adaptive and flexible approach. Amelia described how community needs and resources should be considered alongside the skills-set and experience of arts therapists to shape responsive practice:

Working with what the ... community’s needs are, where the therapist is at, what the person can offer, who the clients are – taking all the different potentials and needs into consideration ... because every institution or community is going to be different.

Ella highlighted the stark contrast between the South African context and the more structured environments experienced by arts therapists trained overseas. She emphasised that the local landscape requires practitioners to adapt to multiple, multidisciplinary spaces while consistently advocating for their profession. Evelyn used the concept of being a “shapeshifter” to describe being

flexible and adapting one's practice to meet needs in different settings. Amelia gave a practical example from a skills training programme with social care providers: "I'd often gone in with a psychodynamic frame thinking I'm going to run my five-day course... And what they actually were needing were life skills and trauma debriefing. So literally like put the manuals down and start from scratch."

Flexibility presents challenges. Evelyn, a recent graduate, described the demands of being a shapeshifter: "The flexibility and openness and ground-up approach can be a bit overwhelming." Several participants noted that being open to change and actively developing innovative, creative practices can feel like "breaking the rules" established by more conventional approaches. Therefore, this practice approach demands keen reflexivity to maintain ethical practice and accountability. Chloe considered supervision to be a space where therapists are held accountable, "to be reminded that it's okay to sort of break some of the rules, and to make new ones."

Guideline 5: Create and maintain safe-enough spaces for service users, practitioners and the practice itself

Volatility and lack of resources add complexity to ethical decision-making. The adversities that service users experience (e.g., poverty, violence, crime) cannot be ignored and directly impact therapeutic practice. Safety considerations are context-dependent. Working in these contexts requires a re-framing of creating and maintaining safe spaces. We find "safe-enough" spaces to be more helpful, as this acknowledges the inherent challenges of environments rife with injustice and inequity. Pursuing the illusion of an entirely "safe space" can be misleading and counterproductive when it fails to account for the real threats present in these settings (Scrine, 2021).

Creating safe-enough spaces requires considering safety through a social justice lens, acknowledging how systemic injustice continually challenges lives. Anna described how social change is considered alongside therapeutic outcomes: "A big shift...needs to happen on all levels for the system to change, while the practice is happening alongside." Through this lens, the concept of safety is intrinsically linked to agency. The focus shifts from solely pursuing individual clinical outcomes towards creating conditions that enable people to actively challenge the systemic injustices affecting them. Agency was linked to a resource-focused approach. Mia suggested that considering safety through a social justice lens keeps the therapist accountable: "If we're thinking about the safety, if we're thinking about the empathy and we're thinking about the agency, that helps us be accountable." Scrine (2021) introduces the idea of "structuring safety" (p. 9) as an ongoing process. It involves practitioners consistently ensuring informed consent, creating opportunities for autonomy, and recognising efforts to counter systemic oppression.

Ensuring safety is driven by ethical practice, including consent and confidentiality. Sophia reflected on how ethical principles guided her practice: "...you've got to tick some of those boxes. You have to have consent. You have to stick to confidentiality." Anna described how their organisation navigated the challenges of obtaining guardian consent for children to attend therapy in a rural community. Standard procedures involving written and signed consent are often impractical due to low literacy levels and linguistic diversity. Consequently, consent processes need reimagining and intentionality. Anna's account highlights the value of collaborating with community-based

practitioners. These local partners can effectively reach, communicate with, and connect to families in ways that therapists, as outsiders, might not.

Anna alluded to the challenges that several participants raised around how demands made by organisations can jeopardise upholding ethical standards. Chloe described how managers wanted to take photographs during therapy sessions to use as fundraising material, and her role included educating stakeholders around confidentiality:

I fought tooth and nail for that sort of expectation to be revised.... Funders want to see what's going on in the group... and they want to see pictures or... join a group space. It required quite a lot of work around educating funders and marketing people (about) the importance of keeping a safe space.

It is crucial to reconsider conventional notions of therapeutic boundaries as roles expand beyond traditional closed-door therapy settings. This expansion requires reimagining safe practice that acknowledges complexity. Camilla described:

People are going to see you outside of a session, they are going to engage with you in different ways. So I certainly had to revise my idea of what a boundary is, as opposed to my private clients... And there are a number of ways in which we need to show up. That Westernised idea of keeping myself separate is not conducive to building trust even in the therapeutic relationship.

Considering where the work is positioned along the continuum of care informs the boundaries around the role of the therapist and the scope of the practice. Ella explained the importance of having clarity around scope of the work, especially when it exists beyond the confines of clinical therapy:

Because my work is more psycho-educational... I need to know the edges of that work quite clearly because I'm not in a clinical space. It's got a very different intention and frame. So understanding... where do you then refer people on? How can you appropriately do that?... Knowing who to point people to for support both in the professional sphere and in the more clinical space.

Guideline 6: Working in contexts of complex needs requires careful consideration of the therapist's capacity

Working in contexts of complex needs with limited resources appears to increase risk of therapist burnout. The motivation to contribute towards positive social change (even at the micro level) may override awareness of potential threats to self-sustainability. These threats include poor remuneration, heavy workload, and being undervalued. Emma shared an example of this as a newly qualified therapist:

That all led me down a slippery slope... I was getting so much experience and I loved it. But I wasn't being paid enough to pay my rent. So I just take on more work...But that just led to burnout until I wasn't able to work at all.

Arts therapists working outside of private practice contexts need to be intentional about the need to be intentional about engaging in self-care to maintain well-being and professional sustainability. This can include using one's own modality and creativity as a resource.

Financial self-protection is also key. Many practitioners work in non-profit and community organisations, with remuneration below private and public health sector rates. Employment often depends on external funding. Several practitioners seemed to follow the strategy of diversifying their income streams: "I need private practice to sustain me financially in order to do the NGO work" (Camilla).

Therapist sustainability depends on the perceived value of their work within the organisational context. It is crucial for practitioners to have a tangible sense of their intervention's impact. These elements of professional validation and outcome awareness play significant roles in maintaining motivation and resilience in challenging environments: "It's that feeling that what you do has some value, that it has some impact...that you are seen and heard and valued" (Evelyn). The recognition of arts therapy's value is not inherent but requires deliberate 'voice' from the practitioner, involving intentional communication about arts therapy practices and dissemination of evaluation findings.

Arts therapists need to know when to stop. It is imperative to engage in critical reflection regarding practice limitations, and whether the environment adequately supports therapeutic work:

You need to have enough experiences of success or acknowledgement or recognition to keep going back. Sometimes a space is just not ready or able to hold you or take what you're giving, and then you have to move away from that...You need to know your limits... When the context stops feeling me and inspiring me and keeping me interested and engaged, then it's my time to move on. (Abigail)

Ensuring personal safety is essential. Sophia described how she prioritised her own physical safety in a community characterised by high levels of street violence:

I learned...when does it feel safe and not safe to go in; which teacher can I contact to find out if it's okay for me to come to school. I did have a really nice teacher at one of the primary schools... who messaged me once to say don't come today, they're shooting in the area.

Guideline 7: Integrate monitoring, evaluation and research as critical components of best practice

Arts therapies in South Africa are still a young profession, and there is value in evaluating practice and ensuring outcomes are disseminated. This not only supports ongoing development of situated evidence-based practice, but also reinforces advocacy efforts to promote arts therapies as a mental health care service. Participants expressed the need for South African-based research to guide the

development of practice and theory. However, lack of funding and academic support, as well as low levels of self-confidence in research abilities and skills were raised as barriers. Elizabeth was direct about these challenges: “You can’t afford it. There’s no time. Nobody pays you to do research... I’ve got to do clinical practice because that’s what’s going to bring an income.” Evelyn explained:

I’m a big believer that we should be researching the work that we do here... I’m engaged with people from all over the world and I see that actually we have so much to say. Our training and our way of working here is spectacular and so innovative...I think the rest of the world can learn so much from us.

Ethical research in arts therapy should prioritise collaboration, inclusivity and transparency (Stige & McFerran, 2016). Elizabeth highlighted the potential of arts therapies research, particularly in low-resource settings, to foster more collaborative and inclusive research methodologies. She underscored the unique capacity of arts-based approaches to engage participants beyond verbal communication:

Engaging people beyond the verbal...in the South African context and where people also are tired of researchers talking at them...Letting themselves be known in ways that are beyond the verbal is a very powerful space. (Elizabeth)

We can build on collective knowledge. As Abigail explained, “Getting [arts therapists] to record their experience, measuring them against others, having resources so that everybody isn’t inventing the wheel every time...not always working from the same base.” When practitioners document and share their work with others we are all able to learn from each other and avoid reinventing strategies. Best practice is also evidenced through this. By systematically recording and sharing experiences, the profession can develop a robust knowledge base that supports continuous improvement and innovation. Collaborative research fuels advocacy and professional credibility. As Elizabeth argued,

Unless we are articulating who and what we are and what we are doing... Our advocacy is deeply affected by the lack of research. It’s not just about being in the sphere of arts therapists internationally, it’s about holding a position in mental health in this country in relationship to the other players in the sector and having something to stand on. It’s absolutely imperative.

Guideline 8: Strive for effectiveness and sustainability in arts therapy-based organisations

A significant portion of community-based arts therapy work occurs within NGOs/NPOs, many established specifically to address the lack of access to arts therapies outside of private practice. The effective functioning of these organisations is crucial to support arts therapy practice and provide quality services.

Effective organisations are characterised by strong organisational structures managed by skilled individuals and led by capable leadership. Chloe emphasised how “Leadership... in these spaces is such a critical and key role.” Reflecting on her experience of working in an organisational

context she stated: “There wasn’t enough emphasis put on employing skilled people to create the structure needed for sustainable continuation.”

In guideline 1, we discussed the importance of the practitioner’s reflexivity. However, reflexive practice is also crucial for developing and sustaining effective organisations that remain responsive to service user needs. Camila illustrated how her organisation used her skills to support their focus on developing a culture of reflexivity.

Organisations have a responsibility to support and nurture the capacity of practitioners (care for the carers), enabling them to effectively hold, contain and support the needs of service users. This necessitates a holistic approach to practitioner support, encompassing considerations such as family responsibility, personal safety and mental well-being. Holistic support structures are crucial in maintaining practitioner resilience and effectiveness.

Interventions need to be designed and rolled out comprehensively. While maintaining clear boundaries around service scope, organisations should consider the multilayered needs of those they serve. Anna shared a practical example: “We just built in food in all of our budget line items. It became standard practice...food has to be where the sessions happen.”

Arts therapists can play a role in mediating between funders and community needs, even though this can be challenging Anna described this challenge:

[Funders’] hearts are big and they really do care, but they’ve got their own objectives, and the needs of the community is something different. I have to think so much about how to bridge and keep everyone happy and do my work.

This mediation role requires skilful communication and negotiation to balance diverse stakeholder interests while prioritising community needs.

CONCLUSION

As a young and developing profession in South Africa, arts therapy faces unique challenges that necessitate an unwavering commitment to excellence. The limited pool of arts therapists in the country amplifies the impact of individual conduct on the field’s collective reputation. This situation demands adherence to high ethical standards, as any instance of professional misconduct could potentially tarnish the entire profession’s image. Therefore, it is imperative for each arts therapist to model excellence in their practice, not only for personal and professional growth but also to safeguard and advance the credibility and recognition of the field as a whole. By consistently demonstrating ethical, competent, and innovative practice, arts therapists can collectively strengthen the profession’s standing and pave the way for its continued development and acceptance within the broader mental health landscape.

We do not present these eight guidelines as a “rule book.” We offer them as an invitation and a contribution to an ongoing conversation. Our findings are limited in terms of the contexts that the participants have worked in, but they are also richly embedded in and informed by these diverse contexts. We hope this study will stimulate similar research in other countries. We also recommend additional research into approaches and support for clinicians to disseminate practice outcomes

through research and global collaborations within the arts therapies that raise the profile of clinicians in developing contexts.

Arts therapists working outside of private practice contexts in South Africa (and, we imagine, other developing countries) face “wicked problems” (Ritchey, 2013, p. 1) on a daily basis (problems that are complex, not clearly formulated, unique, messy, tricky, unstructured, unstable, connected to other wicked problems, do not keep still, and do not have established solutions). It is insufficient to just study wicked problems in the hope that we can tame them by understanding them. We make progress on wicked problems when we actively get busy working in these contexts, trying interventions, problem-solving on the ground and share our experiences. Useful approaches to wicked problems include welcoming multiple perspectives, focusing on and drawing from relationships and exploring multiple conceivable solutions (Ritchey, 2013). The arts therapists who shared their experiences in the discussions for this study are actively and reflexively engaging in these approaches and their insights and contribution are invaluable.

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Ελληνική περίληψη | Greek abstract

«Γίνοντας ένας μεταμορφωτής»: Προς την ανάπτυξη κατευθυντήριων οδηγιών βέλτιστης πρακτικής για τις θεραπείες μέσω τεχνών εκτός του ιδιωτικού τομέα στη Νότια Αφρική

Sunelle Fouché | Andeline dos Santos | Nataly Woollett

ΠΕΡΙΛΗΨΗ

Οι θεραπείες μέσω τεχνών αποτελούν ρυθμιζόμενα επαγγέλματα στη Νότια Αφρική. Παρόλο που το Συμβούλιο Επαγγελματιών Υγείας έχει καθορίσει το πεδίο δραστηριότητας αυτών των επαγγελμάτων, δεν υπάρχουν κατευθυντήριες γραμμές βέλτιστης πρακτικής, ιδιαίτερα για τους επαγγελματίες που εργάζονται εκτός του ιδιωτικού τομέα και σε αναπτυσσόμενα περιβάλλοντα όπου το πεδίο δράσης είναι ευρύ, οι ανάγκες διάχυτες και η πρακτική είναι πολυδιάστατη. Μέσω έξι ομαδικών συζητήσεων εστίασης (focus groups) και δύο εις βάθος συνεντεύξεων με 20 θεραπευτές μέσω τεχνών που εργάζονται εκτός του ιδιωτικού τομέα, διερευνήσαμε τον τρόπο με τον οποίο εργάζονται (συμπεριλαμβανομένων των προκλήσεων και των ηθικών διλημμάτων που αντιμετωπίζουν), πώς ανταποκρίνονται σε αυτές τις προκλήσεις, ποιοι πόροι χρησιμοποιούνται, καθώς και πώς αντιλαμβάνονται τους ρόλους και τις ευθύνες τους. Συλλέγοντας και αναλύοντας αυτά τα δεδομένα μέσω θεματικής ανάλυσης, επιδιώξαμε να αναπτύξουμε κατευθυντήριες οδηγίες βέλτιστης πρακτικής για αυτά τα πλαίσια. Προτείνουμε και συζητάμε οκτώ κατευθυντήριες οδηγίες για μια ευαίσθητη και υπεύθυνη πρακτική των θεραπειών μέσω τεχνών στο εκάστοτε πλαίσιο, παρουσιάζοντας τη λογική και τις εφαρμογές τους. Οι οδηγίες αυτές ίσως να φανούν χρήσιμες σε όλους τους επαγγελματίες που επιδιώκουν να εργαστούν με τρόπους που ανταποκρίνονται με ευαισθησία στο εκάστοτε πλαίσιο.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

θεραπείες μέσω τεχνών, κατευθυντήριες οδηγίες βέλτιστης πρακτικής, κοινότητα, εικαστική θεραπεία, χοροθεραπεία, δραματοθεραπεία, μουσικοθεραπεία

ARTICLE

Towards developing best practice guidelines for arts therapists working outside of private practice: Insights from a scoping review of South African practice

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ABSTRACT

Guidelines for best practice are systematically developed recommendations to optimise service user care. Our purpose in this study was to develop best practice guidelines for art therapists working outside of private practice settings in South Africa. We conducted a scoping review of research on art therapy, drama therapy, and music therapy outside of private practice in South Africa from 2013 to 2023. (No relevant papers related to dance/movement therapy were identified). Based on the themes we developed from analysing the literature, we propose and discuss five best practice guidelines for arts therapists when working outside of private practice settings: (1) It is essential to build one's contextual knowledge continuously and to work in and with that context; (2) To work outside of private practice settings as an arts therapist requires the skills and willingness to engage in wise, humble, strategic, and collaborative relationship-building with a range of partners; (3) To work outside of private practice settings as an arts therapist requires intricately multifaceted reflexive and responsive thinking and practice; (4) The ability to draw on the arts as a highly flexible resource is essential; and (5) To work outside of private practice settings as an arts therapist necessitates creative, optimistic, macro, and micro problem-solving. We unpack the rationale for each guideline and reflect on their practical applications. We acknowledge the unique aspects of our context whilst arguing that lessons could be learned from studying the work occurring here that may be useful for others in their contexts.

KEYWORDS

arts therapies,
best practice
guidelines, art therapy,
dance/movement
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INTRODUCTION

Guidelines for best practice are systematically developed recommendations that aim to optimise service user care. They are developed through the review of evidence and the assessment of current practices. Guidelines for best practice inform practitioners in making the best decisions possible. They also guide improvements in the quality of service provision and policy making. The goal of developing such guidelines is to develop guidelines that are relevant, important, and sound (El-Harakeh et al., 2020).

Best practice guidelines within the health professions are often developed for specific conditions treated in particular contexts. A few authors have proposed practice guidelines in the arts therapies, particularly in art and music therapy. For example, Hackett et al. (2017) developed practice guidelines for art therapy with children and adults with learning disabilities. Spiegel et al. (2006) proposed best practice guidelines for art therapy for combat-related PTSD, and Brooker et al. (2007) developed clinical practice guidelines for art psychotherapy with people prone to psychotic states. Examples of studies proposing practice guidelines within music therapy include interventions with hospitalised children (Stouffer et al., 2007), specifically within paediatric oncology (Gooding, 2012), with LGBTQ service users (Whitehead-Pleaux et al., 2012), and in the context of dementia care (Mercadal-Brotons et al., 2021).

South African contexts

As researchers located in this context, our focus in this study was on arts therapies outside of private practice in the South African system. We acknowledge the unique aspects of this context whilst arguing that lessons could be learned from studying the work occurring here that may be useful for others in their own contexts, particularly arts therapists in other developing countries.

Many people living in South Africa endure chronic poverty (Aliber, 2003). Patel and Graham (2021) reported that as of 2015, 55% of South Africans live below the poverty line (defined as having R760 per month (approximately \$38.68)). Approximately 19 million South Africans depend on state-delivered social grants in the form of cash transfers for the most vulnerable (Mokhutso, 2022). Access to healthcare in South Africa is difficult and the quality of services received is not always sufficient (Coovadia et al., 2009). The healthcare system is starkly divided between private and public sectors, reflecting the country's social and economic contrasts (Burger & Christian, 2020). Mental healthcare has been regarded as "a peripheral and insignificant part of the health sector" (Nguse & Wassenaar, 2021, p. 305). This has been enormously detrimental for people living with mental illnesses, both acute and chronic. Those who are socioeconomically disadvantaged in South

Africa are more likely to experience poor health, comorbid (and multimorbid) conditions, disability, and need inpatient care (Gordon et al., 2020) due to the social and structural drivers of poor health in our context (Bradshaw, 2008). More than 25 years after Apartheid was dismantled in South Africa, inequality in relation to accessing quality healthcare is still significantly stratified in racial terms (Mhlanga & Garidzirai, 2020). Most South Africans consult traditional and Western healthcare practitioners, but there is a lack of integrative collaboration between these healing systems (von Fritschen & dos Santos, 2023).

Many South African contexts are also plagued by violence. South Africa has one of the highest rates of violent crime in the world (Hoosen et al., 2022). Gender-based violence is a widespread problem impacting nearly every aspect of daily life (Enaifoghe et al., 2021). The trauma resulting from exposure to such violence is significant and complex (Woollett & Bandeira, 2020). For example, while lack of access to contraceptive information and poverty have been found to drive unintended teenage pregnancy, sexual violence has also been found to play a vital role (Aliber & Ezegbe, 2020).

South Africa is not only a country of challenge and struggle. It throbs with vibrancy and resilience (Ebersöhn, 2020; Fouché & Stevens, 2018; Garden, 2017; Kinnear, 2023; Pavlicevic & Fouché, 2014). Arts therapists working outside of private practice in South Africa choose to journey alongside service users in these simultaneously resource-less and resource-filled spaces.

The arts therapies in South Africa

The arts therapies—art therapy, dance/movement therapy, drama therapy, and music therapy—became regulated professions in South Africa, registered with the Health Professions Council (HPCSA) in 1999 (Pavlicevic, 2001). Since then, the settings in which arts therapists practice have significantly expanded, as has the body of literature describing practice in these contexts. In South Africa, arts therapists register in the same category at the HPCSA (with their specialisations noted on their registrations; HPCSA, 2022). We collaborate through a shared organisation: the South African National Arts Therapies Association (SANATA). There are relatively few arts therapists in South Africa and it is beneficial for us to recognise our shared values and perspectives, while embracing and learning from our unique skills and knowledge.

Our understanding of the distinctions between work that is inside and outside of “private practice” is informed by the South African healthcare context, by many years of experience working as arts therapists in this country, and by literature that reflects on health services in South Africa (Burger & Christian, 2020) and the role of the arts therapies in particular (e.g., Fouché & Stevens, 2018; Lotter & van Staden., 2022; Mayson, 2020; Moonga et al., 2025; Solomon, 2006). In private practice, arts therapists can bill third-party insurers. They tend to work alone and set up their own clinical space. They are accountable to their client or the client’s guardians, and confidentiality is clearly defined. Arts therapists in private practice are sought out for their services based on their expertise within their HPCSA-regulated scope of practice. In this context, there tends to be a clearer recognition of the issue that is being addressed and consensus regarding the focus of the client’s needs. Arts therapists who work outside of private practice in community contexts navigate complex systems. They tend to be paid by an organisation or through funding raised by a non-profit organisation. Some arts therapists also offer a percentage of their time for voluntary work. Working

in teams is common (for example, multidisciplinary teams in government hospitals where many role players have access to patients' files). Accountability is more complex, involving, for example, an organisation, the service user, teachers, other psychosocial support staff. Parents/guardians of patients may not be accessible for consultation. More psychoeducation may be part of the therapeutic process and there are ubiquitous psychosocial demands. Mental health needs may be multiple and comorbid, and are contextualised within and influenced by many unmet basic needs. As a result, there may be less clarity regarding the specific need that requires therapeutic attention, and a service user may arrive in the presence of an arts therapist out of curiosity or because of the structure of a programme they are part of (not because they purposefully and individually sought out therapeutic intervention). There may be low levels of understanding in the organisations that these arts therapists work in regarding their skills and scope of practice. Therefore, arts therapists working in these contexts need to be highly flexible.

Community-based work outside of private practice

There are several names for work outside of private practice: community-based therapy, public sector therapy, agency-based therapy, non-profit therapy, community mental health therapy, or public health therapy. In the literature related to drama therapy, we find references to "community-based drama therapy" (Cohen & King, 2013), "community-based therapeutic theatre" (Ngong, 2016), drama therapy as community-engaged activism (Sajnani, 2016), "ecological drama therapy" (Hart, 2013), and drama therapy within community theatre (Chang, 2016), to name only a few. In dance/movement therapy studies, we see, for example, references to community engagement projects (Berger, 2021; Copteros et al., 2024; Harris, 2007; Sharp, 2020), community-based dance/movement therapy programmes (Kunte et al., 2024), dance/movement therapy in the community (Steiner, 2003), and community outreach (Pylvänäinen, 2008). As with the other modalities, the work is not necessarily referred to with specific terminology, as we see in the example of dance/movement therapy in collaboration with a non-profit organisation working with asylum seekers and refugees (Kita, 2020).

Referring to art therapy specifically, Jackson (2020) highlighted that community-based art therapy is referred to in many different ways, including, for example, "participatory arts", "community-based participatory arts", "community-based arts programming", "itinerant art therapy", "community-based art studios", "studio-based community art therapy", "public practice art therapy", "socially committed community art action", "social action art therapy", and "group-oriented community-based expressive arts". Jackson argued that "perhaps the importance of community-based art therapy practice does not lie in the semantics of what it is labelled" (p. 86). Community-based art therapy practices can unfold in a wide variety of spaces and be defined by those who participate collaboratively within them. The purpose of this scoping review relates less to debating semantics and more to exploring how practice is unfolding and what guidelines can be helpful.

Nolan and Mumpton (2023) also noted how community art therapy has been called many things and has taken on many shapes. Communities have idiosyncratic elements requiring careful consideration and ethical responsiveness, yet there are still common factors in practice. These

authors argued: "one ideal already noted in the literature is that community art therapy involves an art therapist or trained helping professional who practices with intention and engages in ethical and critically reflexive practice" (p. 2). Their study found the following common factors, even as community art therapy continuously grows and develops: Community art therapy is a setting and an approach practiced in context and shaped by the culture of those in the particular community. It centres creative practices that afford therapeutic benefits for individuals and groups. Community art therapy is accessible, inclusive, and provides an experience of belonging. Community art therapy cares about and addresses inequality and social injustice. It expands beyond the medical model and intrapsychic foci. Community art therapy fosters egalitarian and interdependent relationships. Lastly, it is embodied and nurtures nervous system regulation.

Based on experience and a synthesis of relevant literature, Ottemiller and Awais (2016) offered a best practice model for community-based art therapy. Their model holds five key components: establishing goals collaboratively with community participants (that centre strengths and social inclusion); laying extensive groundwork; being transparent about one's roles, goals, and limitations (which can include education about what art therapy is); making sure that shared decision-making is an ongoing process throughout; participants should have the freedom to label themselves as they see fit (collaborators, contributors, artists, participants, etc.) and art therapists may wish to refer to themselves as such or with terms such as facilitator to avoid the stigma of therapy attendance. In the US, Elmendorf (2010) proposed that community-based art therapists are faced with thinking about new goals within the new settings they work in, potential parallel processes with arts-based community building, community arts and applied arts, developing new language for their work, and careful answers to new questions. For example, "What is my agenda and how can I be clear about my agenda?" (p. 42).

Music therapists have also been wrestling with these questions for a few decades. As community music therapy was developing and being debated, Ansdell (2014) proposed the following areas for a community music therapist's critical investigation: *Identities and roles* (Who am I as a music therapist? What am I expected to do as one?); *Sites and boundaries* (Where do I work as a music therapist? Where are the limits to this work? What are the limits on what I do there?); *Aims and means* (What am I trying to do as a music therapist and why? How do I go about achieving these aims?); *Assumptions and attitudes* (On what theoretical assumptions do I base all of the above? How do these ideas affect my attitude towards people and music?). Stige and Aarø (2012) explained that community practice can be characterised using the acronym PREPARE: it is participatory, resource-oriented, ecological, performative, activist, reflective, and ethics-driven. In the South African context, community music therapy practice has notably contributed to how the profession has taken shape in the country (Fouché et al., 2025; Oosthuizen & Zanders, 2025; Sparks, 2025).

In light of a discussion of "community-based therapies" within South Africa, the term "community" holds some problematic connotations from within the Apartheid times because it was used to refer to people grouped according to race and class. Arts therapists working in South Africa have described how they use a more nuanced understanding of "community", distinguishing between communities of location, identity, and interest. As an example, Swanepoel and Conradie (2023) explained how, when they refer to a community-based model of mental health care, they are "sensitive to its social-economical and historical connotations and understand the differentiations

within communities, as well as the fact that a brief community of shared interest has formed for the duration of the programme, with its unique characteristics, needs and strengths” (p.122).

OBJECTIVES

Our purpose in this study was to conduct a scoping review of the literature on arts therapies work outside private practice in South Africa and to discuss the findings as a starting point for developing best practice guidelines. (In a separate, related paper, we report on findings from focus groups we conducted with arts therapists working these contexts.) Best practice guidelines may be a helpful tool for arts therapists working in these contexts to support effective and ethical practice that is sustainable both in terms of service provision and in relation to the arts therapists’ ability to continue the work over time. The complexity of the context we were examining and the fact that we were exploring all four arts therapies modalities—art therapy, dance/movement therapy, drama therapy, and music therapy—meant that we were in somewhat uncharted territory for developing best practice guidelines. As an initial step, and as somewhat of a “mapping” exercise, we felt that a broad exploration was an appropriate starting point.

Our specific research questions were as follows:

1. What contexts outside private practice are arts therapists working in within South Africa?
 - 1.1 What challenges do people face when living in these contexts?
 - 1.2 How do people living in these contexts cope with these challenges?
 - 1.3 What projects/programmes are arts therapists running in these contexts?
 - 1.4 What are their roles and responsibilities?
2. What challenges and dilemmas do arts therapists face when working in these contexts?
 - 2.1 How do they navigate these challenges and dilemmas?
 - 2.2 What resources do they draw on when working in these contexts?
3. How can the insights from this literature contribute to developing best practice guidelines for arts therapists working outside of private practice settings?

METHODOLOGY

Presenting the methodological process transparently is essential when developing best practice guidelines (Rosenfeld et al., 2013). In this paper, we describe our process of conducting a scoping review of all the articles and dissertations/thesis from the last ten years that include information on how arts therapists work outside of private practice settings in South Africa, which we drew on to inform the development of best practice guidelines. Scoping reviews involve synthesising and analysing a range of relevant research and non-research texts to gain conceptual clarity about a specific topic (Davis et al., 2009). According to Anderson et al. (2008), “scoping studies are concerned with contextualising knowledge in terms of identifying the current state of understanding; identifying the sorts of things we know and do not know; and then setting this within policy and practice contexts” (p. 10). Scoping reviews are used for “reconnaissance” as researchers work to

clarify definitions and conceptual boundaries regarding a topic or field. They are helpful when a body of literature has not been comprehensively reviewed (Peters et al., 2015). Scoping reviews are useful tools for developing best practice guidelines (Pollock et al., 2024).

Our goal was to include all the papers that have been published related to this topic, regardless of methodology, so that we could map what we do know and identify where the gaps are. All the papers identified and included in this scoping review were descriptive, qualitative accounts of arts therapies processes (including qualitative research studies and perspectives on practice). We do not have studies that measure outcomes of particular interventions related to the arts therapies outside of private practice settings in South Africa. We discuss this in relation to the limitations of our provisional guidelines later in the paper. In the section on recommendations for future research, we also speak directly to this.

Inclusion and exclusion criteria

We began the research study in 2023 and elected to focus on literature from the previous ten years (2013-2023). As our objective was to develop best practice guidelines that could inform the work moving forward, we wanted to focus on current contextual characteristics. We included journal articles, Masters and Doctoral dissertations/theses and book chapters. Due to the challenges of defining the exact boundaries around the contexts we were exploring in advance, we used a broad range of search terms. Once we identified texts, we carefully screened them to assess whether the context was situated in private practice, in which case it was excluded. We also carefully screened the identified texts to ascertain whether they included any information related to our research questions.

Searching and screening procedures

We used the following databases to search for literature: Google Scholar, EBSCOhost (Academic search complete), Sage journals, Scopus, Pubmed, and Psycinfo. To search for studies within art therapy, we used the following terms: "South Africa" AND "art therapy" OR "art psychotherapy" AND school OR afterschool OR community OR hospital OR clinic OR prison OR centre OR center OR programme OR program OR workshop OR facility OR home AND challenge OR ethic* OR dilemma OR difficult OR resource OR strateg* OR role OR responsibilit*.

For studies within drama therapy, we used these terms: "South Africa" AND "drama therapy" OR "dramatherapy" AND school OR afterschool OR community OR hospital OR clinic OR prison OR centre OR centre OR programme OR program OR workshop OR facility OR home AND challenge OR ethic* OR dilemma OR difficult OR resource OR strateg* OR role OR responsibilit*.

To identify research within music therapy, we used the following terms: "South Africa" AND "music therapy" AND school OR afterschool OR community OR hospital OR clinic OR prison OR centre OR centre OR programme OR program OR workshop OR facility OR home AND challenge OR ethic* OR dilemma OR difficult OR resource OR strateg* OR role OR responsibilit*.

Lastly, for studies within dance/movement therapy, we used the terms listed below: "South Africa" AND "dance/movement therapy" AND school OR afterschool OR community OR hospital OR

clinic OR prison OR centre OR centre OR programme OR program OR workshop OR facility OR home
AND challenge OR ethic* OR dilemma OR difficult OR resource OR strateg* OR role OR responsibilit*.

Figure 1 displays the process of identifying studies for inclusion.

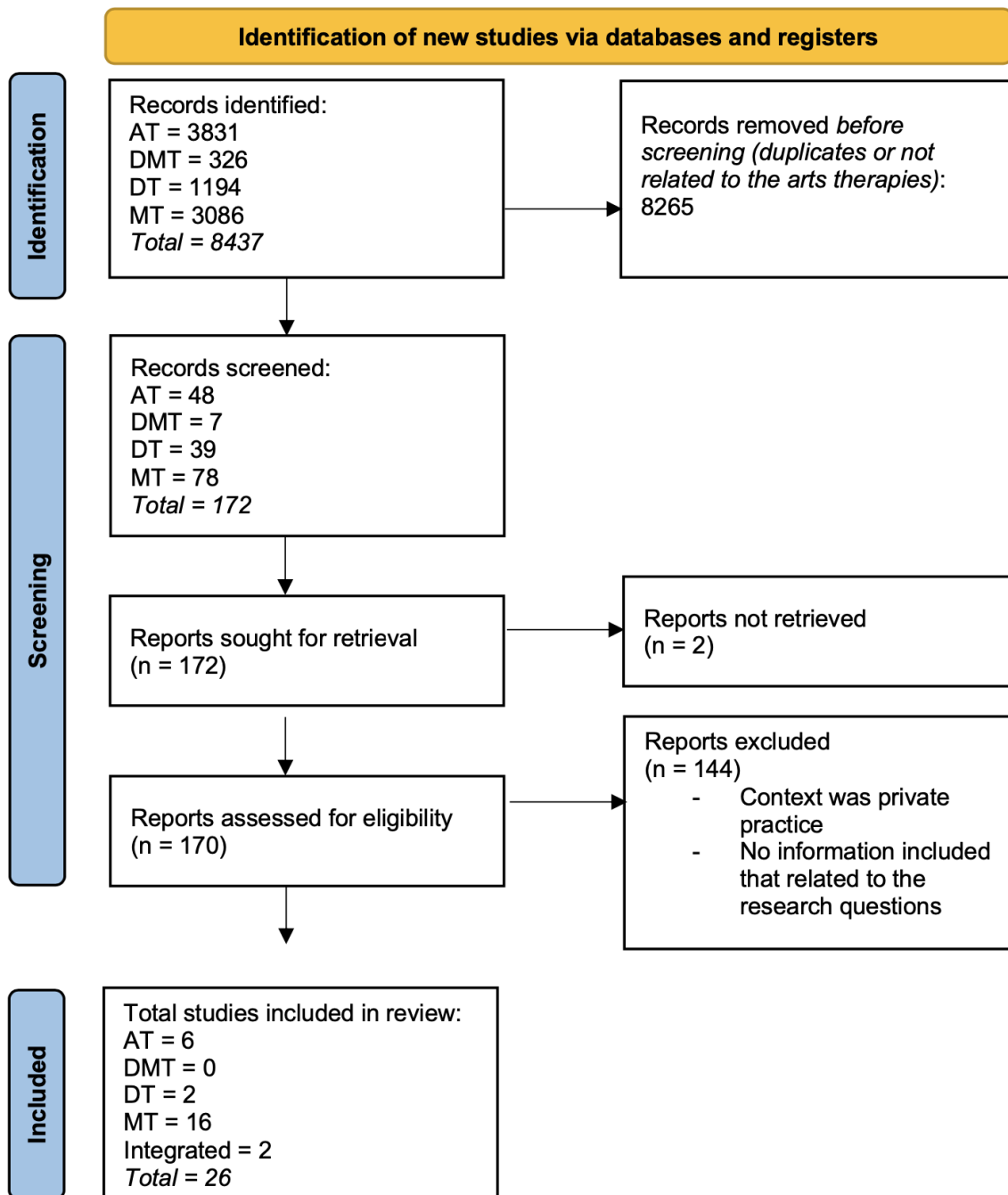


Figure 1: Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram outlining the identification of studies for inclusion in the research

Andeline screened the initial 8437 identified texts, removing duplicates and texts that did not relate to the arts therapies, resulting in 172 remaining studies (two of which could not be accessed). She then listed these and marked them for inclusion or exclusion, providing a rationale for all exclusions. Nataly and Sunelle reviewed the list of included and excluded studies and two excluded

studies were disputed. One was confirmed as excluded, and the other was included (it had been regarded as taking place in a private practice context, but upon close inspection, we saw that it was conducted outside of private practice). This process resulted in a list of 26 studies for inclusion in the scoping review. Table 1 lists the 26 included studies, divided according to modalities.

ART THERAPY	
1	Berman, H., & Woollett, N. (2019). Art therapy's contribution to alleviating the HIV burden in South Africa. In M. Wood, B. Jacobson, & H. Cridford (Eds.), <i>The international handbook of art therapy in palliative and bereavement care</i> (pp. 376-386). Routledge.
2	Booth, M. (2013). Supporting educators to support learners: an art counselling intervention with educators. <i>Matatu</i> , (44), 171.
3	Kinnear, S. (2023). 'There is a sense of bravery in having to make a mark': Resilience and art therapy in South Africa. <i>South African Journal of Arts Therapies</i> , 1(1), 50-71.
4	Speiser, V. M., & Speiser, P. (2022). There are no silos when we are all suffering: Interviews and reflections on ubuntu and the arts in South Africa during COVID-19. <i>Creative Arts in Education and Therapy (CAET)</i> , 8(1), 71-88.
5	Woollett, N., Bandeira, M., & Hatcher, A. (2020). Trauma-informed art and play therapy: Pilot study outcomes for children and mothers in domestic violence shelters in the United States and South Africa. <i>Child Abuse & Neglect</i> , 107, 104564.
6	Zimeray, A. (2022). <i>Expressive arts therapy with pregnant adolescents in South Africa: Observations and reflections on intimate partner violence and intergenerational transmission of violence</i> . [Master's dissertation, Lesley University].
DRAMA THERAPY	
7	Busika, N. F. (2015). <i>A critical analysis of storytelling as a drama therapy approach among urban South African children, with particular reference to resilience building through Intsomi: Intsomi story method a dramatherapy approach</i> [Master's dissertation, University of the Witwatersrand].
8	Spykerman, N. (2017). <i>Building self-care practice through drama therapeutic techniques: A case study of the Zakheni Arts Therapy Foundation's wellbeing workshop</i> . [Master's dissertation, University of the Witwatersrand].
MUSIC THERAPY	
9	dos Santos, A. (2019). Empathy and aggression in group music therapy with teenagers: A descriptive phenomenological study. <i>Music Therapy Perspectives</i> , 37(1), 14-27.
10	dos Santos, A. (2020). The usefulness of aggression as explored by becoming-teenagers in group music therapy. <i>Nordic Journal of Music Therapy</i> , 29(2), 150-173.
11	Fouché, S., & Stevens, M. (2018, October). Co-creating spaces for resilience to flourish: A community music therapy project in Cape Town, South Africa. In <i>Voices: A World Forum for Music Therapy</i> , 18(4).
12	Garden, C. (2017). <i>Exploring the role of music therapy in enhancing protective factors for the resilience of youth at risk</i> . [Master's dissertation, University of Pretoria].
13	Hiller, K. (2019). <i>Mother voices: an exploratory study on the experiences of music therapy for pregnant women in distress from the Cape Flats</i> . [Master's dissertation, University of Pretoria].
14	Lotter, C., Mattison, N., Shroeder, C., & Pollard, A. (2022). Frontline Support: Responding to the COVID-19 mental health crisis in South Africa through online arts and music therapy. <i>Approaches: An Interdisciplinary Journal of Music Therapy</i> , 1-19.
15	Oosthuizen, H. B. (2018). Working with and within chaos: The development of a music therapy programme for

	young sex offenders in South Africa. In <i>Voices: A World Forum for Music Therapy</i> , 18(4).
16	Oosthuizen, H. O. (2019). The potential of paradox: Chaos and order as interdependent resources within short-term music therapy groups with young offenders in South Africa. <i>Qualitative Inquiries in Music Therapy</i> , 14(1).
17	Oosthuizen, H. (2023). Unleashing the potential of chaos: How music therapists and young people can engage chaos as a resource in short-term music therapy groups. <i>Nordic Journal of Music Therapy</i> , 1-18.
18	Pavlicevic, M., & Fouché, S. (2014). Reflections from the market place—community music therapy in context. <i>International Journal of Community Music</i> , 7(1), 57-74.
19	Pavlicevic, M., & Cripps, C. (2015, November). Muti Music-In search of suspicion. In <i>Voices: A World Forum for Music Therapy</i> , 15(3).
20	Pavlicevic, M. (2017a). Action: Because it's cool. Community music therapy in Heideveld, South Africa. In B. Stige, G. Ansdell, C. Elefant, & M. Pavlicevic (Eds.), <i>Where music helps: Community music therapy in action and reflection</i> (pp. 93-98). Routledge.
21	Pavlicevic, M. (2017b). Reflection: Let the music work: Optimal moments of collaborative musicing. In B. Stige, G. Ansdell, C. Elefant, & M. Pavlicevic (Eds.), <i>Where music helps: Community music therapy in action and reflection</i> (pp. 99-112). Routledge.
22	Pavlicevic, M. (2017c). Reflection: Crime, Community, and Everyday Practice: Music Therapy as Social Activism. In B. Stige, G. Ansdell, C. Elefant, & M. Pavlicevic (Eds.), <i>Where music helps: Community music therapy in action and reflection</i> (pp. 223-242). Routledge.
23	Schulze, C. A. (2018). <i>The role of music therapy in the exploration and construction of identity by adolescent survivors of child sexual abuse: A multiple case study</i> . [Master's dissertation, University of Pretoria].
24	Stuart, K. (2018). Musical ripples and reflections: The story of Charlie, his music and his new foster family. <i>Voices: A World Forum for Music Therapy</i> , 18(4).
INTEGRATED PROJECTS	
25	Meyer, K. (2014). Making fires: Rethinking the possibilities of creative arts therapy practice in South Africa. <i>Journal of Applied Arts & Health</i> , 5(3).
26	Errington, K., Errington, S., Oosthuizen, H., & Sangweni, N. (2013). Dancing drumming and drawing the unspeakable: An exploration of an arts-based programme as complementary interventions in the diversion of youth sex offenders. <i>Matatu</i> , (44), 55.

Table 1: Studies included in the scoping review

DATA EXTRACTION AND ANALYSIS

We created an Excel spreadsheet in a shared folder, with separate sheets for art therapy, drama therapy, music therapy, and integrated arts therapies projects. As we read through each of the 26 studies, we extracted information related to the context (including the venue/organisation where the work took place, the challenges faced by people living in these contexts and how they navigated these challenges), the project/programme that was facilitated (including the therapists' goals and outcomes related to working with service-users in managing their challenges in these contexts), the therapists' roles and responsibilities, the challenges and dilemmas that the arts therapists encountered when working in these contexts, and how they navigated these challenges and

dilemmas. If the paper did not present any of this information specifically (even if the work was situated outside of private practice) then the paper was not included.

Andeline copied and pasted the text related to these aspects from the article/dissertation/chapter into the spreadsheet. Then, in a column alongside, she created a code to summarise the essential meaning(s) of that section of text. Nataly and Sunelle were able to review the process (seeing the full-text quotations and the codes that were developed) and add their comments if they disagreed with the coding that had been assigned. Guided by reflexive thematic analysis (Braun & Clarke, 2022), we pulled all the codes out of the spreadsheet and organised them into themes and subthemes according to the principal foci of the first two research questions (and their sub-questions). We colour-coded the codes from art therapy (in red), drama therapy (in green), music therapy (in purple) and integrated projects (in blue) so that whilst building overarching themes, we could still see how each modality was represented within them. We held regular meetings to discuss the unfolding themes.

As authors, we recognise that we are stakeholders. We each have experience working as arts therapists outside of private practice in South Africa. Andeline conducted her doctoral research in a public school setting, working with teenagers referred for aggressive behaviour. She has also worked with community healthcare workers, offering training paid for by external funders (anonymised reference). Sunelle has worked as a music therapist outside private practice contexts for 20 years. Much of this time has been spent with MusicWorks. This non-profit organisation offers music-related psychosocial support services to people living in under-resourced areas in and around Cape Town. Nataly has also worked in various contexts outside of private practice as an art therapist, including supporting and upskilling lay counsellors in public health care and with the organisation Lawyers Against Abuse.

Six papers identified for this review included one of us as co-authors. An additional five concerned projects relate to an organisation that Sunelle has been involved in. While this gave us beneficial insider knowledge that could shape our understanding of the topic under investigation, we are also sensitive to how our investment, lived experience and commitment to the work inform our interpretations and conclusions, which required ongoing critical reflection. We are also educators and supervisors who seek relevant information to share with our students to prepare them for work in these contexts. We have experiences that skew our perspectives as well as richly inform our understandings. Both the methodology involved in developing best practice guidelines and the methodological steps of a scoping review celebrate rigour, objectivity, and minimising bias. This critical realist approach seeks to work towards a most accurate understanding while still acknowledging that human beings perceive the world imperfectly and incompletely, and that it is as a community of researchers that we can proceed closer and closer to the fullest picture of reality (Matney, 2019).

Proponents of acknowledging and working reflexively as researchers highlight that every form of research (not only a qualitative study) is shaped by the researchers who conduct it (Dean, 2017; Jamieson et al., 2023; Weber, 2003). We are all active role players in making meaning in our studies. It is unwise to pretend otherwise (by claiming value-free objectivity). Instead, we can honestly and insightfully acknowledge this, work with it, and present a transparent depiction of our motivation, decisions, and interpretations. Working in a research team is invaluable in this regard. Throughout

the process of this study, we met frequently to critically examine our thinking, preconceived ideas, methodological choices, how we were actively interpreting the data, and how we could best represent our findings. Reflexivity can be greatly enhanced by working in a team (Barry et al., 1999).

FINDINGS

Table 2 presents our final organisation of themes and subthemes in response to our research questions. Literature on arts therapies work in South Africa outside of private practice highlighted contexts related to sexual and reproductive health, abuse, education, the mental healthcare system and COVID-19. Projects that are designed to support people in these contexts were explored. A range of challenges were mentioned, including concerns related to economic insecurity, safety, housing, ill health, lack of access to healthcare, racial injustice, educational inadequacies, and lack of access to the arts. Arts therapists saw their roles as including specific therapeutic interventions as well as being social activists. They needed to be flexible, collaborative, and ensure the sustainability of their programmes. They faced foundational challenges such as lack of resources, lack of other's understanding of the arts therapies, chaotic systems, and difficulties obtaining consent. They navigate these through reflexivity and flexibility, drawing on the arts as a resource and working to ensure safer environments in which the work could be conducted. They sought opportunities for additional funding, valued learning from participants, and drew on contextually relevant theory to underpin their work, as well as growing through supervision. Arts therapists in the included studies drew on dialogical ethics, worked collaboratively, and built trusting relationships with communities over time.

1. What contexts outside of private practice are arts therapists working in South Africa?

HIV, sexual health, pregnancy, sexual abuse
Education
Mental healthcare system
COVID-19

1.1 What challenges do people face in these contexts?

Economic
Threats to safety
Drug abuse
Racial injustice
HIV/AIDS
Homelessness
Unemployment
Inadequate healthcare and mental healthcare systems
Under-resourced educational systems
Developmental challenges for youth
Lack of arts access

1.2 How do people living in these contexts cope with these challenges?

Resilience
Additional programmes offered by schools and organisations
Less constructive strategies to get needs met

1.3 What projects/programmes are arts therapists running in these contexts?

HIV, sexual health, pregnancy, sexual abuse:

- experiential art therapy group with HIV counsellors
- Trauma-informed art and play therapy intervention with mothers and children in domestic violence shelters
- Caring, Affirming and Training for Change (CATCH) – victim empowerment programme (for persons who have experienced sexual abuse)
- Teddy Bear Clinic (for sexually abused children); diversion programme for youth convicted of sexual offences (Support Programme for Abuse Reactive Children (SPARC) – diversion programme)
- Programmes for pregnant teenagers who have experienced intimate partner violence and are HIV positive or HIV at risk
- Hanover Park Midwife Obstetric Unit

Child welfare

Education

- Art counselling groups for educators
- Group music therapy at a high school in a community context of unemployment, drug usage, and violence
- Music therapy at a primary school in the Cape Flats within a context of community violence
- Music Therapy Community Clinic / MusicWorks
- Youth Development Outreach (YDO; adolescent development program)
- Dumezweni Primary School, Diepkloof, Soweto

Mental healthcare system:

- The Zakheni Arts Therapy Foundation's Firemaker Project trains community care workers
- Firemaker programme (skilling care workers to use the arts for psychosocial support of vulnerable children)

Covid-19:

- Frontline Support

1.4 What are their roles and responsibilities?

Specific therapeutic roles and tasks

Their roles need to be flexible

Knowledge of and working sensitively with and in the context

Collaborating

- Stepping back
- Humility
- Managing power relations carefully
- Managing insider-outsider status

Ensuring sustainability

Social activists

2. What challenges and dilemmas do arts therapists face when working in these contexts?

Foundational challenges

* Resource challenges

Working in an under-resourced mental health system

Lack of creative arts therapists

Limitations of online therapy

Funding challenges

* Knowledge challenges

Lack of contextual understanding

Lack of fit between arts therapists learned theories and service users' worldviews

* Relational challenges

Feelings of chaos and unpredictability

Service users' resistance
 Struggles engaging with children's families
 Challenges related to work during COVID
 Challenges related to who has the rights/legitimacy to engage in arts-based healing in South Africa
 Challenges working in organisations with colleagues who don't understand or support ATs
 Challenging in navigating boundaries
 Ethics: Challenging with obtaining consent
 Ethics: Challenges maintaining confidentiality

* Safety challenges

Safety fears

Challenges related to responses to the foundational challenges

* Emotional/psychological challenges

Overwhelm and hopelessness

2.1 How do they navigate these challenges and dilemmas? and 2.2 What resources do they draw on when working in these contexts?

Reflexivity
 They think, practice and respond flexibly
 Drawing on the arts as a resource

Responding to foundational challenges

* Resource challenges

Compensating community facilitators and reimbursing participants for data use
 They seek funding
 Using online platforms for therapy

* Knowledge challenges

Valuing and growing one's knowledge of service-users' worldviews
 Using accessible, strengths-based language
 They learn from participants
 They go to supervision
 Drawing on more contextually relevant theory

* Relational challenges

Drawing on dialogical ethics
 Working in more collective ways (as opposed to individual sessions)
 Encouraging service-users and partners to take ownership
 Respectful, non-pressurising interactions with participants
 Building trusting relationships with communities over time
 They collaborate with others

* Safety challenges

Working to ensure greater safety

Responding to challenges related to responses to the foundational challenges

* Emotional/psychological challenges

Hope and enthusiasm

Table 2: Themes and subthemes

It is important to note that 16 of the identified studies were situated in music therapy, six in art therapy, two in drama therapy, zero in dance/movement therapy, and two entailed integrated reflections. As mentioned, while there are also other published articles about arts therapy practices

outside of private practice, these papers did not include information on the specific topics we were investigating (i.e., the authors did not reflect on the challenges of the context; they focussed solely on the techniques and the outcomes). Music therapy training in South Africa has the longest history of the four modalities, which is probably a key driver behind why more music therapy articles were identified. Within the literature from each modality, there are also some prominent voices. We need more research across the arts therapies, particularly in dance/movement therapy and drama therapy. Research into how arts therapists who work outside of private practice experience and negotiate the contextual challenges they face can be valuable to others working in similar contexts. Most of the research has been published by white music therapists working as outsiders in community contexts they do not live in. We need a wider range of diverse voices. We do acknowledge, however, that both “insider” and “outside” roles can helpfully offer different perspectives and insights (when reflected upon critically and engaged in with care). We acknowledge that the findings in this current study more heavily reflect the experiences of music therapists and art therapists, and this is a limitation of the research in terms of the guidelines we can offer. However, it is a valuable finding in terms of encouraging the direction of future studies.

DISCUSSION

Based on the themes we developed from analysing the literature, we propose and discuss five guidelines for arts therapies best practice when working outside of private practice settings. Below, we unpack the rationale for each guideline and reflect on the application of these guidelines, drawing on insights from the reviewed studies and related literature.

Guideline 1: When working as an arts therapist outside of a private practice setting, it is essential to build one’s contextual knowledge continuously and to work in and with that context

Arts therapists operate within varied social, economic, and political contexts, necessitating an understanding of how these environments influence their work and the people they serve. Without increasingly deep contextual understanding, arts therapy processes are more difficult and potentially less helpful for service users. In the literature analysed for this current study, we saw examples of arts therapists navigating cultural contexts, organisational contexts (Oosthuizen, 2018), and the realities of daily life experienced by people in particular (e.g., under-resourced) contexts. For example, Zimeray (2022) highlighted transportation issues causing stress and session disruptions. Participants’ hunger also impacted session effectiveness. Busika (2015) noted similar issues with tired and hungry primary school children in her drama therapy sessions. These daily life challenges shaped the format and characteristics of therapy sessions. Some arts therapists face challenges due to cultural differences (Makanya, 2014; Oosthuizen, 2018; Spykerman, 2017; Zimeray, 2022). Mayson (2020) argued that if therapy is offered in a manner that is ignorant of diversity, it can cause a misaligned and untrusting relationship between client and therapist and can result in low adherence, slow therapeutic progression, and impasses or miscommunication in therapy.

Theoretical frameworks that underpin conventional approaches to the arts therapies often fail to address the complexities of clients' lived experiences. For example, Fouché and Stevens (2018) pointed out that Western theoretical constructs may not fully capture how people in less formalised health contexts thrive amidst ongoing trauma. In terms of communication within contexts that arts therapists work outside of private practice, engaging with service users' families and communities is crucial but can be challenging. Oosthuizen (2018), for example, struggled with obtaining consent and integrating community involvement in therapy. Confidentiality issues and the chaotic elements of communal life in this context further complicated therapy sessions. The importance of including the broader community to support individual growth was emphasised. During the COVID-19 lockdowns, therapists had to navigate new challenges in online contexts. Lotter et al. (2022) discussed issues like compromised musicking, difficulties reading body language, and ethical concerns regarding privacy and confidentiality when conducting sessions online and telephonically.

To apply this guideline, firstly, building contextual knowledge and learning to work with the context needs to be an intentional endeavour. Whitehead-Pleaux et al. (2017) stressed that client assessment should explore the service-user's cultures of heritage, generational influences, survivor experiences, location, identity, socio-economic factors, disability, gender identity, and religion. Stepney (2022) similarly noted cultural dimensions in art therapy assessments. Effective therapists must deepen their understanding of these dynamics. Arts therapists should value local knowledge, cultural practices, and how participants derive meaning, drawing on existing resources in the process.

Ottmiller and Awais (2016) emphasised that art therapists should integrate social justice into their practice, ensuring cultural competence as mandated by art therapy education standards. As Meyer (2014) highlighted, "most arts therapists are white and trained in a privileged western paradigm" (p. 306) and argued that a more socially just agenda would involve "understanding and addressing how the social, economic and political contexts within which we work influence us and our clients" (p. 305).

Arts therapies practices should adapt to the social dynamics of the context, as noted by Pavlicevic (2017b), who described community music therapy's interaction with local norms and social-musical affordances. Pavlicevic and Fouché (2014) discussed how therapists could focus on musical facilitation that benefits community development rather than providing direct therapy. In her work, Stuart (2018) highlighted how she became "increasingly aware of how music therapy is shaped by and shapes the communities in which [she] worked" (p. 2).

Secondly, one should specifically value and grow one's knowledge of service users' arts practices. It is important for therapists to familiarise themselves with the history and development of local art styles. Pavlicevic and Cripps (2015) explored how this knowledge may be limited if one is an outsider, but still described how "leaning in" happened when they witnessed a traditional music healing ceremony. Pavlicevic (2017c) described a music therapist who, "despite her own expertise in music therapy work... is aware of her lack of expertise when it comes to local music genres and events" (p. 228). Therefore, she mentors the young people she works with while also learning from them.

Thirdly, arts therapists should recognise and work with existing strengths and resources (Oosthuizen, 2018). We draw on the affordances of the arts as psychosocial tools within the contexts

in which we are working. This does not only apply to what we do, but how we talk about what we do. Arts therapists highlighted the importance of moving away from “problem-based” language as well as using language that is accessible to all participants and stakeholders (Pavlicevic, 2017c).

Fourthly, one should draw on contextually relevant theories and models. The theories that arts therapists identified as helpfully grounding and directing their work included indigenous theoretical perspectives (Busika, 2015; Spykerman, 2017), trauma-informed approaches (Woollett et al. 2020), paradox theory (Oosthuizen, 2019), resilience-informed frameworks, Ebersöhn’s (2012, 2020) theory of flocking, and ecological approaches (Fouché & Stevens, 2018).

Guideline 2: To work outside of private practice settings as an arts therapist requires the skills and willingness to engage in wise, humble, strategic and collaborative relationship-building with a range of partners

Arts therapies in community contexts are, by definition, inclusive and involve shared decision-making (Ansdell & Pavlicevic, 2004; Goldstein Nolan & Mumpton, 2023; Ottemiller & Awais, 2016; Stige, 2015). This approach ensures that diverse voices are heard and valued (Stige & Aarø, 2011). The practice is based on respect, humility, and a resource-oriented ethos, where therapists develop mutually beneficial partnerships with communities, respect local health priorities, and act as students and partners (Jackson, 2020; Tervalon & Lewis, 2018). However, collaborative approaches can be challenging. For example, Oosthuizen (2018) highlighted the difficulties involved in starting work as a music therapist as part of a team within an organisation.

To apply this guideline, firstly, arts therapists should include collaborative role players who cut across the disciplinary and practice spectrum, and include service providers and service users as decision-makers. Arts therapists are encouraged to distribute decision-making power to create “Communities of Dialogue” (Tervalon & Lewis, 2018, p. 48). Working outside private practice is inherently collaborative, even for solo arts therapists, who learn from participants and negotiate health and therapeutic goals collectively (Busika, 2015; Oosthuizen, 2018). The therapist’s role is to support participants in making their own decisions and setting their own rules, rather than directing the process (Stige et al., 2010). This participatory approach requires careful thought and execution, with therapists considering their role, the appropriate level of support, and when and if to intervene (Ansdell et al., 2020).

Collaborative efforts can extend to task-sharing with non-mental health specialists (Berman & Woollett, 2019), partnerships with food services (Speiser & Speiser, 2022), and collaborations between music therapists (MTs) and community musicians (Fouché & Stevens, 2018; Pavlicevic & Fouché, 2014). Projects also include engaging with teachers (Pavlicevic, 2017b), referral teams (Lotter et al., 2022), community artists (Meyer, 2014), intern therapists, and volunteers (Lotter et al., 2022). They involved building good relationships with colleagues within the organisation (Oosthuizen, 2018), working with a local person with more contextual knowledge, and working with a local person who can translate (Zimeray, 2022). Some projects, such as Firemaker (Meyer, 2014), also involved collaboration across the arts therapies. Frontline Support (Lotter et al., 2022)—offering arts therapies online during the COVID-19 pandemic—“was conceptualised as a non-hierarchical

organisation valuing collaboration and co-ownership by all volunteers” (p. 3). Meyer also emphasised the importance of being careful not to undermine community arts programmes and other applied arts methods. Such collaborations ensure community programmes are ethical, sustainable, and tailored to local needs. Speiser and Speiser (2022) described how Lefika La Phodiso, which facilitates art therapy informed processes, creatively adjusted during COVID-19, with many of their teenagers willing to assist with younger children as “volunteens” (p. 74). Zimeray also highlighted the importance of attending supervision. In the case of her project, this was group supervision used to process the therapeutic dynamics.

Secondly, a collaborative approach entails times when the therapist steps back and service users can take ownership (Pavlicevic, 2017c). Communities take ownership and the arts therapist then provides support. Meyer (2014) discussed how essential it is to encourage partner organisations to take ownership of programmes. Offering opportunities for ownership is balanced with respectful, non-pressurising interactions with participants (Oosthuizen, 2018).

Thirdly, it must be held in mind that humility is essential for authentic collaboration. For example, Pavlicevic (2017c) described music therapist Carol Lotter’s work at a youth development organisation (YDO) alongside community facilitators who function as mentors:

Carol says that despite her own expertise in music therapy work, she is aware of her lack of expertise when it comes to local music genres and events. From Carol’s description, the mentor becomes part of group musicing together with his young charges. Musicing together enables all to relinquish their YDO-defined identities and social hierarchies, and instead become collaborative musicians. The same happens to Carol – she becomes the ‘backup musician.’ (p. 228)

Fourthly, working collaboratively involves developing sustainable practice, which involves planning for the programme’s ongoing impact beyond the therapist’s direct involvement, focussing on building participants’ capacities for continued use of skills (Bolger & McFerran, 2013; Pavlicevic & Fouché, 2014; Steele, 2016). While building sustainable relationships often involves thinking about how a project can extend into the future, sustainable relationships are also ones that have been built over time. Building a reliable track record can enhance community openness (Pavlicevic & Fouché, 2014).

Fifthly, arts therapists working outside of private practice should draw on dialogical ethics. Dialogical ethics are central to collaborative practices, emphasising long-term critical dialogue and reflective practice (Meyer, 2014) and fostering community responsibility (Pavlicevic, 2017b).

Sixthly, we should prioritise more collective approaches rather than individual sessions when outside of private practice contexts. Group work was prominent throughout the identified literature (Berman & Woollett, 2019; Booth, 2013; Busika, 2015; dos Santos, 2019, 2020; Errington et al., 2013; Fouché & Stevens, 2018; Garden, 2017; Hiller, 2019; Meyer, 2014; Oosthuizen, 2018, 2019, 2023; Pavlicevic, 2017a, 2017b; Pavlicevic & Fouché, 2014; Pavlicevic & Cripps, 2015; Spykerman, 2017; Woollett et al., 2020; Zimeray, 2022). As Meyer (2014) wrote, “central to debates about what arts

therapists have to offer this mutable world is the potential to move beyond individual therapy into a more collective space to facilitate social justice and change through arts practices” (p. 304).

Guideline 3: To work outside of private practice settings as an art therapist requires intricately multifaceted reflexive and responsive thinking and practice

Working outside of private practice in South Africa as an arts therapist demands a highly flexible and reflexive approach due to the unique and complex contexts encountered. For example, Oosthuizen (2018) wrote, “my work never feels easy and requires constant reflection, not only regarding group and contextual dynamics, but also my own personal and professional process” (p.10). This kind of multifaceted reflexivity requires looking inward and outward, critically reflecting on internal and external responses, being able to locate oneself within interpersonal relationships with service users as well within broader socio-cultural positioning.

Foundational questions for arts therapists involve considerations of who should engage in this work and what the nature of the work should be. Meyer (2014) pointed out that the international professionalisation of arts therapies has generated tensions regarding identity, ethics, and practice, particularly in power-laden contexts. Pavlicevic and Fouché (2014) highlighted the challenge for music therapists to adapt their practices in communities where traditional mental health structures are mistrusted and where the notion of therapy carries social stigma. These complexities necessitate an ongoing dialogue within the field. Questions about the role of music therapy, the intersection with local music practices, and the impact on community well-being are central. Pavlicevic and Fouché noted that pre-agreed frameworks often fail to guarantee success due to external factors like partner organisation struggles or lack of support, which can lead to the decision to halt projects. Safety concerns and the emotional toll on therapists working in high-risk areas are also significant issues. Arts therapists working outside of private practice in contexts like South Africa need to be willing to explore these questions with a brave openness to where the answers may lead and a willingness to adapt in response. In Mayson’s (2020) dissertation on the shape of drama therapy in South Africa, she emphasised the importance of

critical self-reflexivity for therapists: to understand their own assumptions, biases and values... While all therapists should engage in this process of gaining self-knowledge, it is especially crucial when working in diversity... Only through this thorough engagement with self, where personal ignorance and curiosity can be communicated to the client... can a true, authentic and powerful therapeutic alliance be built that can communicate across boundaries. (p. 4)

The literature on arts therapies’ work outside of private practice in South Africa mentions therapists’ experiences of overwhelm and hopelessness, as well as fluctuating feelings of hope and despair (Berman & Woollett, 2019; Hiller, 2019; Kinnear, 2023). Zimeray (2022) shared the realisation that clients may find hope in situations where therapists see none, highlighting the importance of not projecting one’s own feelings onto clients.

To apply this guideline—of engaging in intricately multifaceted reflexive and responsive thinking and practice—firstly, we need to be critically aware of our positioning. Oosthuizen (2018) underscored the importance of situating oneself within the context before beginning therapy. This involves acknowledging one's identity and privilege, as well as understanding the life experiences and backgrounds of group members. Zimeray (2022) discussed the necessity of becoming aware of one's privilege in a tangible way, while dos Santos (2020) explored how her various identities intersected with those of the teenagers she works with, highlighting the dynamic and co-produced nature of these interactions. Meyer (2014) articulated that social justice in arts therapy involves not only addressing the needs of marginalised groups but also confronting one's own positions of power, race, and privilege through reflexive practice.

Secondly, we need to bracket preconceived ideas and assumptions. As an example, dos Santos (2019) described her approach to working with teenagers referred for aggression, resolving to set aside assumptions about them and being fully present to understand who they are and how they choose to share themselves. This openness allows for a more genuine and effective therapeutic engagement.

Thirdly, self-care is an essential part of reflexive practice. Kinnear (2023) emphasised the negative effects of high workloads, resource scarcity, and the risk of burnout for therapists working in public health sectors. Maintaining self-care practices is crucial for sustaining long and healthy careers. This includes being acutely aware of how therapists approach their work, especially when dealing with clients who have experienced significant trauma and violence.

Guideline 4: The ability to draw on the arts as a highly flexible resource is essential for arts therapy work outside of private practice settings

Arts therapists are highly skilled in using their respective modalities flexibly, adapting to different tools and materials to meet clients' needs (Orkibi, 2018). In non-private practice settings, arts therapies often involve collaborative and resource-oriented techniques, expanding beyond conventional clinical methods. This includes musical performances, therapeutic theatre, playback theatre, and community murals. For example, Mayson (2020) noted that drama therapists in South Africa adapt their techniques to fit within participants' socio-cultural contexts and existing community arts practices. However, embracing flexibility in arts therapies raises challenges, such as ensuring informed consent and maintaining confidentiality, as required by the HPCSA. Therapists also often face resource constraints in their working environments, which can both limit and necessitate greater creativity and flexibility. For example, during the COVID-19 pandemic, offering arts therapies online presented both challenges and opportunities. Lotter et al. (2022) found that clients faced difficulties accessing art materials at home and generating creative ideas.

To apply this guideline, firstly, arts therapists working outside of private practice need to think, practice, and respond flexibly. Pavlicevic and Fouché (2014) reflected on the need for music therapists to adopt hybrid and fluid practices that respond to the specific contexts and cultures they work within. Mayson (2020) also noted the necessity for drama therapists to adapt their methods to be culturally sensitive and relevant. Pavlicevic and Cripps (2015) emphasised the importance of

"going with the flow" (p. 5) and maintaining a stance of generosity and inclusiveness. This involves continuously asking questions, exploring possibilities, and valuing even chaotic elements as potentially beneficial (Oosthuizen, 2018, 2019, 2023). The roles of all participants can be seen flexibly. Pavlicevic (2017b) described how community members in the Heideveld project took ownership of a concert, shifting the therapists' roles from organisers to musical supporters.

In music therapy work outside of private practice, Oosthuizen (2019) emphasised the importance of using flexible musical frameworks. Pavlicevic (2017b) highlighted that music therapists' strategies are dynamic, improvisational, and closely tied to the group's enactment at any moment, reflecting the unpredictable nature of social-musical interactions. Pavlicevic and Fouché (2014) discussed the importance of an improvisational attitude in music therapy, where the focus is not solely on musical quality but on creating a process that allows children to explore and learn about themselves through shared musical experiences. This approach values the process over the product, emphasising personal and communal growth.

During the transition to online arts therapy during the COVID-19 pandemic, as described by Lotter et al. (2022), some therapists found it easy to adapt their modalities to online platforms like Zoom and WhatsApp, while others struggled. These authors found that therapists creatively empowered clients by providing information and resources, and suggesting home setups similar to art therapy studios. Other initiatives included sharing music folders, sending music between sessions, using poems and journaling for music composition, and utilising virtual instruments, enhancing client engagement and access to arts therapies despite the limitations.

Secondly, arts therapists should mine the arts as a resource. Oosthuizen (2018) emphasised music's role as a co-therapist, enhancing participation, belonging, and emotional release among young people, illustrating the arts' potential to foster connections and manage group dynamics. Berman and Woollett (2019) highlighted the transformational potential of art therapy, emphasising the need for practitioners to attune to multiple layers of engagement. These layers facilitate physiological changes, enhance empathic connections, and promote social cohesion and well-being. Using the non-verbal medium of the arts can foster trust, communication, and curiosity, enabling group members to process trauma, bereavement, and multiple losses. Image-making processes can provide a means to communicate complex emotions and reflect on personal experiences, enhancing understanding and resilience. Art therapy workshops, such as those described by Zimeray (2022), used techniques like body-mapping and collage to help participants identify sources of support, resilience, and envision their life stories. These methods empower individuals to address challenges and find solutions.

Guideline 5: To work outside of private practice settings as an arts therapist necessitates creative, optimistic, macro, and micro problem-solving

The authors of the identified studies in this research discussed complex challenges within the contexts they work in, which necessitated creative problem-solving. This can be difficult because of feelings of hopelessness (Berman & Woollett, 2019; Zimeray, 2022) and financial constraints (Pavlicevic & Fouché, 2014). Safety concerns loom large for arts therapists working outside private

practice, particularly in areas marked by violence and instability. Hiller (2019) vividly described the anxiety and perilous conditions she encounters while conducting therapy sessions in Hanover Park. Fouché and Stevens (2018) elaborated on the burden carried by teachers in violent-prone areas, where exposure to violence is endemic and systemic causes remain unresolved. The work happens in “edgy” (p. 61) places – where violence is unbridled and (state) structures that uphold personal security are largely absent (Pavlicevic and Fouché, 2014).

The COVID-19 pandemic added another layer of complexity, with therapists grappling with shifting lockdown stages and limited client access to therapy. Spieser and Speiser (2022) discussed the difficulty of providing safe spaces amid a broader lack of safety, while Lotter et al. (2022) noted the challenges posed by reduced client access and limited time for each client during the pandemic.

To apply this guideline of creative, optimistic, macro, and micro problem-solving, arts therapists should, firstly, nurture and protect hope and enthusiasm. As highlighted by Berman and Woollet (2019), “as practitioners, we need to embrace the complexity, beauty and transformational potential of this work” (p. 384). In the words of Pavlicevic and Fouche (2014), “therapists are trained to understand and work with the psychosocial complexities underpinning health, aspirations, need and hope” (p. 64). In the *Handbook of hope*, Snyder and Feldman (2000) suggested that individuals with higher levels of hope tend to think more about communal or shared goals along with pathways to achieve them.

Secondly, arts therapists working outside of private practice tend to need to seek funding creatively. For example, Lotter et al. (2022) highlighted the need for a data fund to support marginalised clients' access to online therapy. Spieser and Spieser (2022) exemplified creative adaptation by launching the *Yellow Umbrella Project* to address food shortages among children, ensuring access to art-based educational and therapeutic programs.

Thirdly, there is a need to create spaces that are safe enough. Ensuring physical and emotional safety is paramount for arts therapists working in challenging environments. Pavlicevic and Fouché (2014) emphasised the importance of creating safe spaces within dangerous contexts:

One of our responsibilities is to create safety in the context of danger: needing to know the dangers so as to know how to be safe – not creating a false sense of security or safety – but position safety within the very context of danger. We involve the children in creating and ensuring safety. Within this safe environment, together we can generate musicking experiences through which everyone can flourish. We are not avoiding problems or ignoring young people's astonishing resilience. We hope that we are adding to this, nurturing and fostering it, extending their resilience towards flourishing – through music... [We are] creating a safe space, literally, figuratively, experientially – for everyone: the children, the young musicians, and for ourselves. Physically the work keeps children off the streets, and offers them an imaginative space that is there each week, that they can hold in mind the rest of the week: a kind of safety beacon. (p. 66)

LIMITATIONS AND RECOMMENDATIONS FOR FUTURE RESEARCH

We are aware that the findings are shaped in relation to the prominence of music therapy literature that met the inclusion criteria for this study, and the lower numbers of particularly drama therapy and dance/movement therapy papers. This prominence is an important finding in itself. There is an urgent need for further studies to explore the challenges faced by all arts therapists working outside of private practice in South Africa and how they are navigating these challenges so that others can learn from them, reducing the need to “reinvent the wheel”. We also highlight how most of the authors of the identified studies are White and are working with service users who are not. As training programmes intentionally graduate groups of more diverse arts therapists, we hope that this feature of the literature will start to shift more dramatically.

We need more research into the nuances of how arts therapists working outside of private practice experience and navigate ethical dilemmas. Additional research is also required into how arts therapists can best negotiate organisational relationships, work effectively within severely under-resourced contexts, and build generative networks. The notion of sustainability also requires ongoing research in terms of project sustainability and sustaining one’s personal capacity to keep doing this important work.

CONCLUSION

Through a scoping review, we set out to examine the contexts outside of private practice that arts therapists are working in within South Africa. We wanted to better understand the challenges faced by arts therapists working in these contexts and how they addressed these so that we could propose preliminary best practice guidelines. We found a limited array of studies that spoke directly to our questions, most prominently from within music therapy and art therapy. Through a thematic analysis, we developed main themes that spoke to our research questions and generated guidelines through interrogating these themes and drawing on quotations from the articles to support our interpretations. In relation to previous literature on community-orientated approaches to the arts therapies, this study offers a unique contribution, particularly in its emphasis on the role of collaborative relationship-building with a wide range of role players and its focus on micro and macro problem-solving. We present these guidelines as a starting point for additional research both from the South African context and from within other developing countries.

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Προς την ανάπτυξη κατευθυντήριων οδηγιών βέλτιστης πρακτικής για θεραπευτές μέσω τεχνών που εργάζονται εκτός του ιδιωτικού τομέα: Ευρήματα από μια ανασκόπηση πεδίου της πρακτικής στη Νότια Αφρική

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ΠΕΡΙΛΗΨΗ

Οι κατευθυντήριες οδηγίες για βέλτιστη πρακτική είναι συστηματικά ανεπτυγμένες συστάσεις που αποσκοπούν στη βελτιστοποίηση της φροντίδας των χρηστών υπηρεσιών. Σκοπός μας σε αυτή τη μελέτη ήταν να αναπτύξουμε κατευθυντήριες οδηγίες βέλτιστης πρακτικής για θεραπευτές μέσω τεχνών που εργάζονται εκτός ιδιωτικών πλαισίων στη Νότια Αφρική. Πραγματοποιήσαμε μία ανασκόπηση των ερευνών που έχουν δημοσιευτεί σχετικά με την εικαστική θεραπεία, τη δραματοθεραπεία και τη μουσικοθεραπεία εκτός του ιδιωτικού τομέα στη Νότια Αφρική, για την περίοδο 2013–2023. (Δεν εντοπίστηκαν σχετικά άρθρα σχετικά με τη χοροθεραπεία). Με βάση τα θέματα που αναπτύξαμε αναλύοντας τη βιβλιογραφία, προτείνουμε και συζητάμε πέντε κατευθυντήριες οδηγίες για τη βέλτιστη πρακτική στις θεραπείες μέσω τεχνών όταν εργάζονται σε πλαίσια εκτός του ιδιωτικού τομέα: (1) Είναι απαραίτητο να εμπλουτίζει κανείς συνεχώς τη γνώση του για το εκάστοτε πλαίσιο και να εργάζεται εντός αυτού του πλαισίου και σε συνεργασία με αυτό. (2) Η εργασία εκτός ιδιωτικού τομέα ως θεραπευτής μέσω τεχνών απαιτεί δεξιότητες και προθυμία να δημιουργήσει εύστοχες, ταπεινές, στρατηγικές και συνεργατικές σχέσεις με μια σειρά από συνεργάτες. (3) Η εργασία εκτός ιδιωτικού πλαισίου απαιτεί σύνθετη, πολυδιάστατη, αναστοχαστική και ευέλικτη σκέψη και πρακτική. (4) Η ικανότητα να αξιοποιεί κανείς τις τέχνες ως έναν εξαιρετικά ευέλικτο πόρο είναι απαραίτητη. (5) Η εργασία εκτός ιδιωτικού πλαισίου ως θεραπευτής μέσω τεχνών προϋποθέτει δημιουργική, αισιόδοξη, μακροσκοπική και μικροσκοπική επίλυση προβλημάτων. Αναλύουμε τη λογική πίσω από κάθε κατευθυντήρια οδηγία και εξετάζουμε τις πρακτικές εφαρμογές τους. Αναγνωρίζουμε τα μοναδικά χαρακτηριστικά του δικού μας πλαισίου, ενώ υποστηρίζουμε ότι από τη μελέτη αυτού του έργου μπορούν να αντληθούν συμπεράσματα που μπορεί να είναι χρήσιμα για άλλους στα δικά τους πλαίσια.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

θεραπείες μέσω τεχνών, κατευθυντήριες οδηγίες βέλτιστης πρακτικής, εικαστική θεραπεία, χοροθεραπεία, δραματοθεραπεία, μουσικοθεραπεία

ARTICLE

Including siblings in music therapy: A scoping review

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ABSTRACT

This scoping review examines current research and clinical practice concerning sibling inclusion in music therapy, exploring how sibling participation is described, in what settings, and with what objectives. Sibling relationships are integral to psychosocial development during childhood and adolescence, yet their involvement in music therapy remains underexamined compared to parent-child dynamics. This review included music therapeutic models, programmes, or interventions documented in literature that incorporate siblings of minor age in music therapy sessions or processes, excluding records focused exclusively on parent-child dynamics. A comprehensive search of electronic databases (Scopus, MEDLINE/Pubmed, PsycArticles, Web of Science, Embase, ProQuest) and three journals (Journal of Music Therapy, Nordic Journal of Music Therapy, British Journal of Music Therapy) was conducted in 2024. Keywords included “Sibling”, “Brother”, “Sister”, “Family” and “Music Therapy”. Twenty-eight records met the inclusion criteria. Sibling inclusion was most prevalent in medical and palliative care settings, aiming to foster sibling relationships, enhance family cohesion, and promote coping. Intervention strategies included songwriting, improvisation, structured group activities, and legacy projects. Sessions varied in frequency and duration, with settings ranging from family homes to hospitals. While qualitative insights were rich, quantitative evidence was limited. Findings highlighted music therapy’s potential to strengthen sibling relationships, reduce rivalry, facilitate coping and emotional expression and enhance family cohesion. However, sibling inclusion often occurred incidentally. Four gaps were identified: (i) family-centred versus sibling-specific approaches; (ii) research–practice disparity; (iii) contextual influences; (iv) shifting perspectives. Addressing these gaps requires prioritising siblings as active agents and developing intentional, structured approaches, supported by research.

KEYWORDS

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INTRODUCTION

Music therapy is recognised for its effectiveness in family-centred interventions (Tuomi et al., 2021). Historically, music therapy has primarily focused on parent-child dynamics in family-centred interventions. In recent years, the inclusion of others, such as siblings or extended family members has gained attention, as practitioners and researchers have recognised the unique dynamics that can arise when family members are actively involved in the music therapeutic process (e.g. Edwards & Kennelly, 2016). This paper will focus on the specific inclusion of brothers and sisters, i.e. 'siblings', in music therapy. This definition of 'sibling' also applies to adopted, half- and stepsiblings, and other modern family configurations, where sibling roles are clearly described (see inclusion criteria).

Sibling entity within the family structure

Sibling relationships are often the longest family relationships in a person's life (Cicirelli, 1994). Although sibling interactions are generally more frequent in (early) childhood than in adolescence or adulthood, the quality of sibling relationships remains an important factor for well-being throughout the lifespan (McHale et al., 2012; Waldinger et al., 2007). Sibling interactions differ from parent-child relationships in fundamental ways. The dynamics within the sibling relationship emerge and evolve in part away from the parental eye, enabling siblings to exist as a distinct and independent entity within the family structure (De Groef & Vermote, 2015; McHale et al., 2012). Sibling relationships are shaped by the significant amount of time spent together and by the free and uninhibited expression and mutual influence between siblings, both positive and negative (Dunn, 2002; McHale et al., 2012, 2013; Travers et al., 2020). A key distinction in sibling relationships is their unique perspective on one another, which often diverges from parental perceptions. Unlike parents, who typically adopt an authoritative or caregiving role, siblings often engage from an equal position. For example, in families where one of the children requires additional care due to support needs, siblings often develop a nuanced awareness of the challenges involved. This awareness stems from shared lived experiences rather than caregiving responsibilities, offering a different, often complementary, perspective to the one that parents may hold. Even sibling rivalry can serve a constructive purpose, providing opportunities to learn conflict resolution and compromise—skills less developed in parent-child interactions due to the inherent family hierarchy. Siblings are key contributors to each other's development and well-being, particularly in families with one of the siblings navigating challenges such as disabilities or chronic illness (McHale et al., 2012).

Creativity in interactions

Creativity plays a unique role in enriching sibling relationships by fostering connection, collaboration and mutual understanding (Kramer, 2010). Siblings may even exhibit greater creativity in interaction in their parent's absence, such as in unsupervised play, where they invent imaginative games or role-plays, and need to negotiate and adapt rules and roles dynamically (Howe & Bruno, 2010). Through such creative interactions, siblings develop social skills and learn to regulate emotions both for themselves and each other, which positively impacts their quality of life (Cicirelli et al., 2020). These creative interactions make for a profound familiarity with each other which often persists into

adulthood, allowing siblings to understand each other's preferences and abilities (Dunn, 2002; Travers et al., 2020). When a family experiences adversity, the creative sibling dynamics may either become a valuable coping mechanism or remain in the background. While extensive research exists on (the experience of) caregiving for siblings, especially in cases where a child experiences medical issues (e.g. Commodari, 2010) or has a disability (e.g. Burke et al., 2015; Harland & Cuskelly, 2000; Heller & Kramer, 2009; Rawson, 2010; Rye et al., 2018), the potential of siblings' creative interactions as a resource for support and resilience remains underexplored in research. Given the creative and reciprocal nature of sibling interactions, and their long-life impact, interventions that nurture these creative dynamics – such as music therapy – could provide valuable opportunities. This is particularly relevant in situations where sibling relationships may require additional support, such as in families managing disabilities or chronic illnesses. Here, the emphasis tends to be mostly on the illness or disability and the caregiving responsibilities accompanying these, while the strengths inherent in the sibling relationship itself are often overlooked.

Existing sibling interventions

Professional sibling-focused interventions are often offered when one of the children (the 'focus child') has support needs such as an intellectual disability, autism spectrum disorder, chronic illness or behavioural challenges. Existing approaches typically emphasise psychoeducation: aiming to help siblings better understand the diagnosis or challenges of the focus child, and providing siblings with coping strategies (Wolff et al., 2023). Other initiatives such as immersion days and seminars aim to provide social contact with other siblings, peers, facilitating the exchange of experiences and advice (e.g. Prchal & Landolt, 2009). Despite the benefits of these initiatives (Prchal & Landolt, 2009; Wolff et al., 2023), existing interventions seem to be mostly unidirectional, emphasising the sibling's supportive role without involving the focus child in real-time interactions (see Figure 1).

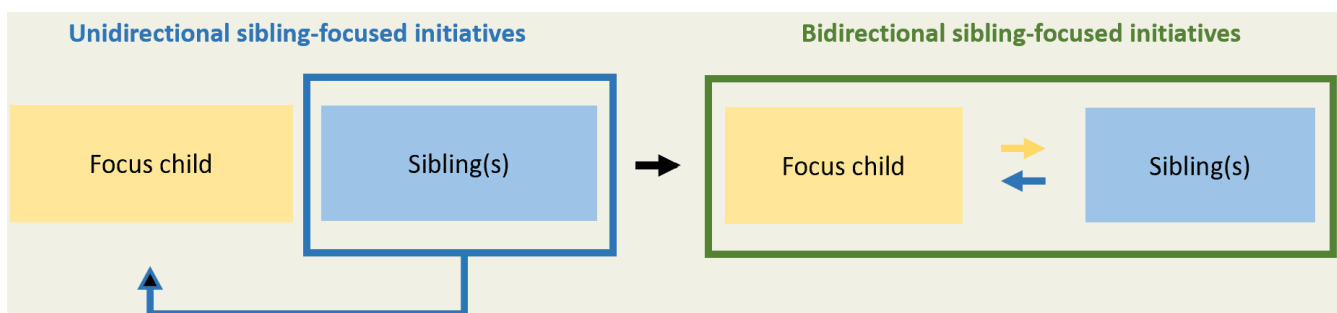


Figure 1: The possible shift from existing unidirectional to bidirectional initiatives using music therapy

Although many initiatives address sibling support, few leverage the creative potential and bidirectionality of sibling relationships. Music therapy, with its inherent emphasis on creativity and reciprocal interaction, offers a unique opportunity to address this gap. A music therapeutic framework for sibling-focused interventions, where siblings and focus children could engage as equals, could be useful in facilitating these dynamics and bidirectional interactions of sibling relationships. By incorporating siblings as active agents within therapeutic sessions, music therapy has the potential to address not only the focus child. It can also engage the inherent creative resources of sibling

relationships, potentially impacting the entire family system. A scoping review was conducted to explore the available literature on the topic, focusing on three objectives: exploring (i) the settings of sibling involvement, (ii) the context and aim of sibling involvement and (iii) working strategies of sibling involvement in music therapy sessions and processes.

REVIEW QUESTIONS

To understand sibling inclusion in music therapy, this scoping review addresses the following questions:

i. Settings¹ of sibling involvement

- In what clinical and research settings are siblings included in music therapy?
- To what extent are siblings involved in the music therapy process?
- Which family members, other than siblings, are present in the sessions?

ii. Context² and aim of sibling involvement

- What are the therapeutic goals of including siblings in music therapy?

iii. Working strategies of sibling involvement

- What music therapeutic intervention strategies are used in the music therapy process?

A scoping review was conducted to address these questions. This method was chosen due to the exploratory nature of the topic and the need to map diverse writings across clinical and research literature and settings. This approach allowed for inclusion of varied sources including grey literature, which is particularly relevant in areas where scarce research literature is available, such as sibling inclusion in music therapy. A scoping review thus allows for a comprehensive exploration of existing literature on sibling inclusion in music therapy. A preliminary search of the Cochrane Database of Systematic Reviews, JBI Evidence Synthesis and Prospero was conducted but to this date no eligible systematic reviews on the topic were identified.

METHOD

The proposed scoping review was based on the recommendations of the Joanna Briggs Institute (JBI) methodology for scoping reviews (Aromataris & Munn, 2020). Ethical approval and informed consent were not required as this paper solely reviews existing literature.

¹ Setting: the physical and environmental conditions in which the music therapy takes place, i.e. hospital, school, etc. (Bruscia, 2014).

² Context: therapeutic goals, client needs and therapeutic approaches that shape music therapy (Bruscia, 2014).

1.1. Inclusion criteria

Concept and context

In this review, 'music therapy' refers to the clinical and evidence-based use of music interventions by a credentialed professional (Bruscia, 2014), distinguishing it from general music education or recreational musical activities. All music therapy models, programs, courses and interventions identifying as music therapy and describing work with siblings in the music therapy sessions were included. There was no limitation in terms of geography or culture. Inclusion covered various theoretical frameworks within music therapy, e.g. psychodynamic or educational music therapy. Only literature in which the siblings and the focus child were both an active agent in the music therapy sessions were included. Literature was excluded (i) when the author gave no information about the active involvement of the siblings and the focus child, e.g. when an author only mentioned siblings as being (possibly) included in music therapy sessions, as an advice for good practice, and no further information was available, or when the research focus lay elsewhere; (ii) when a sibling was seen individually or separately from other siblings or family members and no other family members were active agents (e.g. in a bereavement group with peers); (iii) when no explicit mention was made that siblings were among the included family members in the sessions; (iv) when the siblings were above eighteen years old or when their majority/minority was not specified. Records that were focused exclusively on parent-child dynamics were excluded.

Participants

Only siblings of minor age were included, regardless of gender, development or position in family (e.g. elder or younger sibling, stepsibling, twin etc.). Studies or practices involving adopted, half-siblings, and stepsiblings were included if their participation in music therapy was explicitly documented. This review focuses on siblings of minor age as sibling relationships during childhood and adolescence are crucial for emotional and social development, with creativity playing a key role (Cicirelli, 1994; Dunn, 2002).

Types of sources

This scoping review encompassed a wide range of research designs, including quantitative, qualitative and mixed-method studies. Given the exploratory nature of this review, books, book chapters, conference abstracts, case studies and grey literature were also eligible for analysis. Only studies in English published between 1999 and 2024 (the last 25 years) were included, in order to observe the latest developments in the field.

1.2. Search strategy

An initial limited search of SCOPUS was undertaken to identify relevant articles on the topic. Based on these results, a full search strategy was developed and undertaken using the following databases: Scopus, MEDLINE (Pubmed), PsycArticles, Web of Science, Embase, Proquest, and three music therapy journals (Journal of Music Therapy, Nordic Journal of Music Therapy, British Journal of Music Therapy). Keywords used were sibling, brother, sister, family and music therapy. The search strategy,

including all identified keywords and index terms, was adapted for each included database and/or information source. Relevant references from the identified studies were manually screened, and additional grey literature was considered to ensure the most comprehensive coverage possible.

1.3. Study selection

Number of included articles

The goal of this scoping review was to explore sibling inclusion in music therapy sessions and processes. Because the search string ("music therapy") AND (sibling* OR brother* OR sister*) yielded few feasible results, the search string was adapted to: ("music therapy") AND (famil* OR sibling* OR brother* OR sister*). The keyword 'famil*' was included in the search string to explore more literature, after which the records were screened for siblings within results. This search string yielded 3265 results in six databases and three music therapy journals. Among the citations identified, duplicates were removed and verified manually, leaving 2382 records. After screening for (sibling* OR brother* OR sister*) in title and abstract, yielding 210 results of which three were eligible, the full texts of the initial search were assessed for eligibility, yielding another seven results (see Figure 2 for an overview). In a final stage, additional records containing music therapy work with siblings (n=18), identified through other sources (e.g. references of the included records, book chapters) were manually added to the results. This yielded a total of 28 results. References were managed using Zotero 7.0 software.

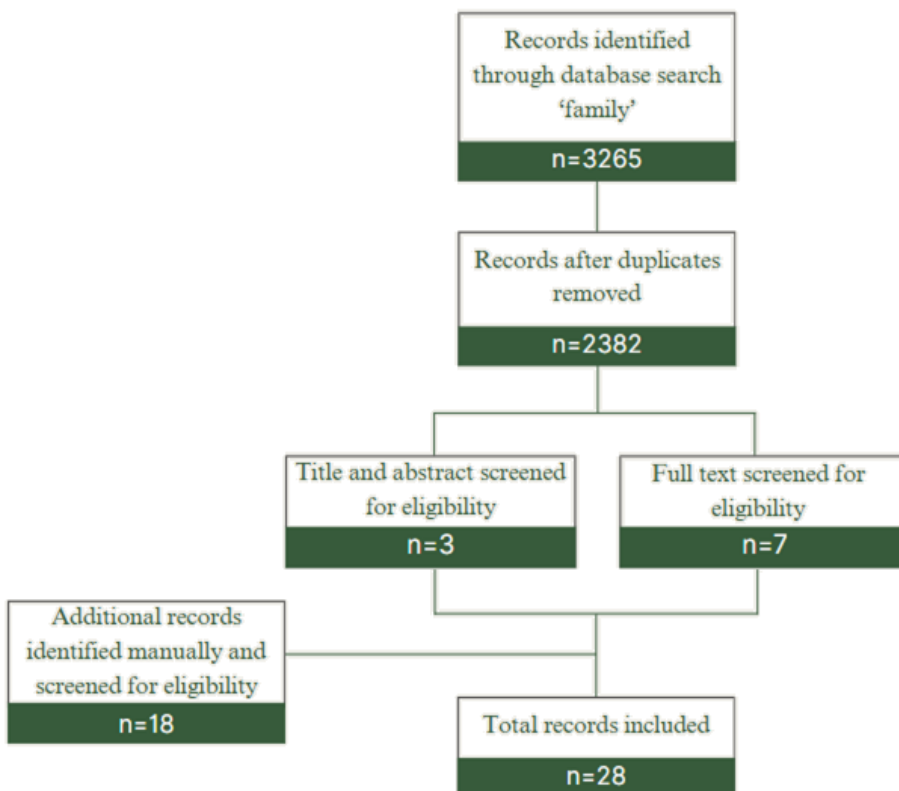


Figure 2: Flowchart of the selection process

Record and study type

A scoping review allows for multiple record sources, hence this paper also included grey literature. In total, 15 out of 28 records are journal articles, nine are book chapters. Also included are one newspaper article, one review, one conference proceeding and one master thesis. The records are mostly descriptive in nature, being case studies (n=11/28) or descriptions of clinical work with case vignettes (n=11/28). One record is a literature review which provides case examples (Duda, 2013). Research articles were more likely to employ a qualitative design such as case and pilot studies or case examples in a theoretical framework or literature review. Research methods employed were thematic analysis, microanalysis and descriptive analysis, derived from interviews, focus groups, observations, surveys and journals. Quantitative methods were notably absent.

RESULTS

The information of the 28 included records pertaining to sibling inclusion was categorised according to the reporting guidelines for music-based interventions by Robb et al. (2011) and described in Table 3 (see Appendix). An example of this data analysis is added below in Table 1. The categories included are: *setting* (where the intervention was delivered, both geographically and the research or clinical environment); *unit of delivery* (which siblings were included (age, diagnosis, etc.), were parents included and how did they influence sibling inclusion (e.g. did they decide if and when the sibling participated in the sessions); *aim of sibling involvement* (e.g. to foster the sibling relationship, as an aid for the focus child, psychoeducational interventions, or due to practical reasons [e.g. when mother could not provide child care]); *intervention strategies* (music-based intervention strategies under investigation [examples: music listening, songwriting, improvisation, lyric analysis, rhythmic auditory stimulation, etc.]); and *intervention delivery schedule* (number of sessions, session frequency and duration) (see Table 1). In the next section, the table components are described in a narrative overview.

Author	Record Type	Study Type	Setting	Unit of Delivery	Aim of sibling involvement	Intervention strategies	Intervention Delivery Schedule
Allgood (2005)	Article	Treatment case study	USA Therapeutic day school for children with ASD Sessions at day school	Family-based group music therapy: Children (4-6yo) with primary diagnosis of ASD, Siblings welcome to attend (done in 2 families). At least 1 parent or primary caregiver present.	Interventions chosen to promote joint attention, interaction among group members, self-expression and cooperative group experiences. No sibling specific aim, but parent stresses importance of sibling inclusion.	Structure music therapy sessions: greeting song, specific music activities, goodbye song, free exploration time. Instrument exercises, movement to music, rhythm-based activities, singing, improvisational music, simple folk dances, music games. Outcome: sibling inclusion important for one of four parents: sessions let sibling see 'positive things' associated with brother's ASD. Sibling shares common experiences and observes her brother successfully interacting with other children and expressing himself musically. Typically developing siblings offer same age model for both musical and non-musical behaviours and are bridge between group members.	Pre-session interview, 7-week family-based group music therapy intervention (45mins each), post session focus group.
Baron (2017)	Book chapter	Theoretical and Clinical work	Australia Paediatric hospital setting Sessions in patient's room	Case: Elizabeth (3yo, leukaemia), brother Ben (6yo) and grandmother. Mother NP (respite).	Let family connect both musically and emotionally, reduce anxiety. Case: first time visiting hospital for brother: engaging in music making to make experience more enjoyable.	Instrument choice, song choice, instrumental play along to familiar songs, encourage all family members to select songs and instruments and sing and play an instrument. Case: active music-making, patient chooses instruments for brother and grandmother, everyone chooses song to sing. Mother joins the session while daughter is singing and reminisces. At end of session, MT encourages mother and grandmother to continue playing in between music therapy sessions and leaves instruments in room.	NS

Table 1: Example of data analysis of included records (NS= not specified; NP= not present; MT= music therapist; names are abbreviated to initials after first use)

Research or clinical setting and country of origin

Sibling inclusion was most frequently documented in hospice and palliative care settings³ (n=11: Daveson & Kennelly, 2000; Duda, 2013; Flower, 2008; Griessmeier, 2005; Hilliard, 2003; K. Lindenfelser et al., 2012; K. Lindenfelser, 2013, 2015; Nall & Everitt, 2005; Noyes et al., 2023; Steinhardt et al., 2021). Five records describe music therapeutic work with siblings in (paediatric) hospital settings (Baron, 2017; Ettenberger, 2017; Goicoechea & Lahue, 2021; Heiderscheit, 2022; Knott et al., 2022). Two records describe the work in schools (Allgood, 2005; Diamond, 2012). Several records describe the work in clinic or centre settings: two records focus on music therapeutic work in child development centres⁴ (Loombe, 2017; Oldfield, 2008), one in a community music therapy clinic (Loth, 2017), one in a mental health service (McIntyre, 2009) and one in a foster care institution (Tuomi, 2005). Four records describe sibling inclusion in a different context: a charity setting (Mitchell, 2017; Woodward, 2004), a recreative setting (Horton, 2004), and a not further specified community action agency (Pasiali, 2017). One study (DeRusso, 2024) did not specify the research setting. Figure 3 and 4 depict the setting of the included records (see figure 3) and the countries where the record originated from (see figure 4).

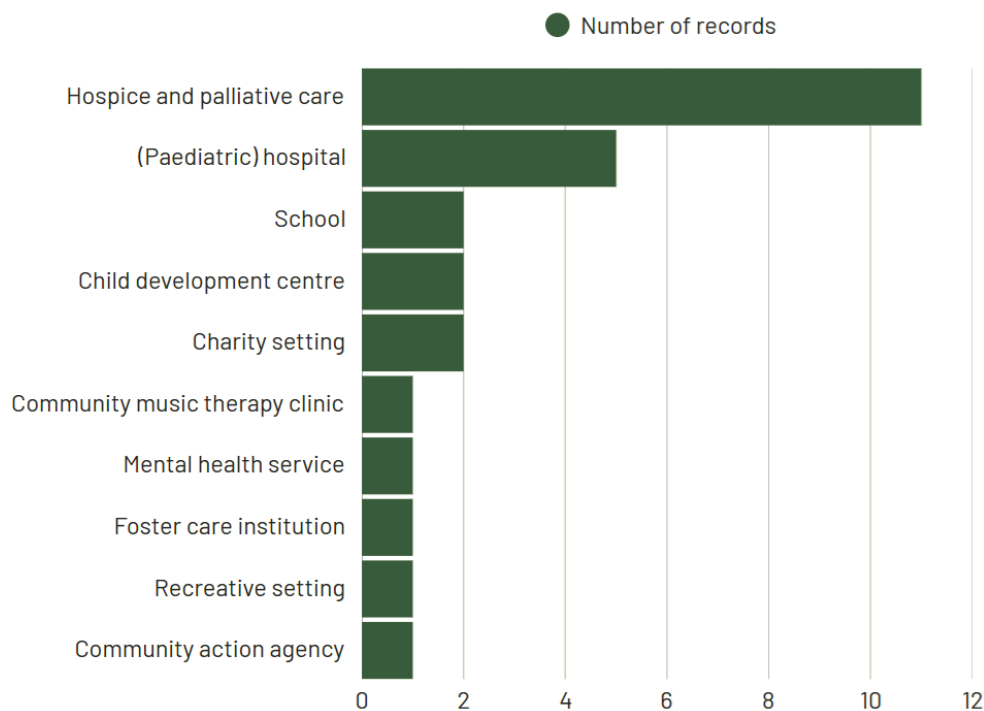


Figure 3: Settings described in the included records

³ In hospice care it is usually determined that a patient has 6 months or less to live and no additional treatment is given except for comfort care (Lindenfelser, 2013). In palliative care settings, patients often still receive treatment but also end-of-life care. In literature, these terms are often used interchangeably, hence they are categorised together in this review.

⁴ In both Loombe (2017) and Oldfield (2008), a child development centre is an outpatient assessment and treatment centre attached to a hospital, where specialised care is available for children and their families.

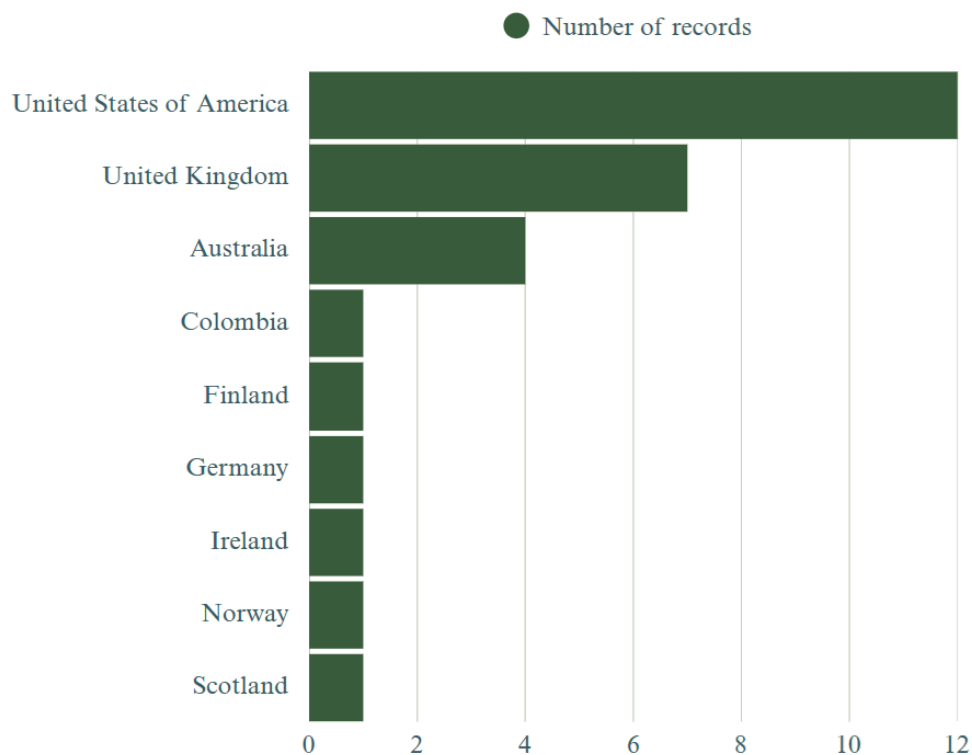


Figure 4: Countries where records originated from

Sessions mostly took place in the family home ($n=8/28$), in hospitals ($n=6/28$, of which 3 in patient's room) and clinic/centre settings ($n=5/28$), coinciding frequently with the hospital and hospice settings. One record describes that sessions take place in an online setting (Goicoechea & Lahue, 2021), and in five records, the location of the sessions was not specified. In some records, several locations were used during the music therapy process (e.g. Lindenfelser, 2013) depending on the focus child's health and surroundings, e.g. at home, in the patient's room, an isolation unit or on the ward.

Most records originated from the United States of America ($n=12$), the United Kingdom ($n=7$) and Australia ($n=4$). Other countries include Colombia (Ettenberger, 2017), Finland (Tuomi, 2005), Germany (Griessmeier, 2005), Ireland (Diamond, 2012), Norway (Steinhardt et al., 2021) and Scotland (Horton, 2004).

Unit of delivery

In this scoping review, records were included when siblings were actively engaged as participants in the session or process. A range of possible family interactions in music therapy was represented in the included literature, ranging from dyadic sibling interactions to interactions between all family members and the music therapist. A predominance was found for sibling interventions that took place in group formats including entire families: in nineteen records ($n=19$) at least one parent or caregiver was sometimes or always present in the music therapy sessions. When parents were not taking part in the sessions ($n=5$), this was mostly because the parents requested not to be present, e.g. focus on sibling-specific dynamics (Goicoechea & Lahue, 2021) or respite care (e.g. Knott et al., 2022; Nall & Everitt, 2005), or because the sessions took place in a day school context (Diamond, 2012). Parents were often present during music therapy settings in hospice and hospital contexts. Five records

explicitly describe the encouraging of including other family members such as grandparents or cousins (Baron, 2017; Griessmeier, 2005; K. Lindenfelser, 2013; Oldfield, 2008; Steinhardt et al., 2021). Two records describe professional staff sometimes being included in the sessions (Knott et al., 2022; Steinhardt et al., 2021). While most records (n=15) did not specify sibling age (e.g. 'older' or 'younger' than focus child), others focused mostly on siblings of preschool and middle school age.

Aim of sibling involvement

Only a few authors have focused on sibling aims specifically. Usually, sibling-focused goals or interventions were included in more general family-centred goals such as the facilitation of family interactions (e.g. for parents or entire family). Key sibling-focused aims (see Table 2) included fostering positive aspects of sibling relationships, facilitating sibling interactions and expression of emotions, and diminishing sibling rivalry, particularly in families with children facing health or developmental challenges (e.g. Loth, 2017; Nall & Everitt, 2005). Another significant aim was facilitating shared coping and reducing anxiety by fostering a sense of normality and offering grief and legacy support in palliative care settings (e.g. Duda, 2013; Goicoechea & Lahue, 2021; Hilliard, 2003; K. J. Lindenfelser et al., 2012). Additionally, some interventions focused on improving family cohesion and facilitating family dynamics. As often the entire family was involved in music therapy, this aim was not sibling specific. However, the siblings were seen as playing a crucial part in family dynamics and in creating shared positive experiences (e.g. McIntyre, 2009; Pasiali, 2017). Sometimes, sibling aims were psychoeducational in nature: including the sibling to help them understand the focus child's challenges and support the focus child's development and develop skills for engaging with them more effectively (e.g. Loth, 2017). Some records did not provide a sibling specific aim (Allgood, 2005; K. J. Lindenfelser et al., 2012; Steinhardt et al., 2021), but sibling-specific outcomes or benefits were inferred from descriptions or parent interviews. Finally, three records described logistical or practical reasons for initially including siblings, such as the absence of childcare, siblings being present in the family home during the music therapy session or parental unavailability (Flower, 2008; Mitchell, 2017; Oldfield, 2008). While this may not have been the primary therapeutic aim, siblings were often deliberately included in subsequent sessions because of the observed benefits.

Intervention content

A variety of intervention strategies were employed, emphasizing creativity and interaction. Common intervention strategies (see Table 2) most often described were: songwriting/analysis and song singing/playing, often combined with legacy projects in hospice contexts, such as making a personal song or heartbeat recording; instrumental exploration and improvisation, which focused mostly on rhythmic activities; music listening (both live and recorded) and guided relaxation; structured group activities, such as 'start-stop' games, turn-taking activities or conducting exercises. Creative expression by way of movement was often part of the activities, especially with young siblings (e.g. dancing on music played by family members or MT or on recorded music). Other notable intervention strategies, described less frequently or with less detail, were vocal improvisation, music instrument teaching, collaborative band playing, performance or jamming. Sibling inclusion from a

distance, such as through letter writing, was also mentioned. Improvisational approaches and the use of familiar songs were particularly prevalent in family-centred music therapy.

Intervention delivery schedule

Frequency and duration of sessions varied widely (see Table 2), from siblings participating in a single session to being included weekly over several months. Sessions at home typically involved shorter but more frequent sessions. Structured sibling involvement seemed to be less common, reflecting the need for flexibility in working with siblings. When siblings were involved in multiple sessions, there was usually also a sibling-specific aim of involvement (e.g. Goicoechea & Lahue, 2021). Some records describe siblings only joining one session, having more broad family goals. Often it was not specified in how many sessions the siblings took part. Table 2 provides a summary of the narrative overview. For more detailed information, see Appendix.

Key findings

This scoping review shows that sibling inclusion has several potential aims and benefits: strengthening sibling relationships and diminishing sibling rivalry, facilitating coping mechanisms and legacy building, fostering emotional expression and enhancing family cohesion. These aims align with broader therapeutic goals of promoting psychological well-being, improving communication and interactions, and supporting family dynamics. The inclusion of siblings seems to be particularly impactful during periods of stress or transition, in contexts where families face challenges such as chronic illness, developmental disorders, or end-of-life care. Music therapy can thus not only benefit the focus child but can also offer siblings and other family members a structured and supportive environment to process their own experiences and contribute meaningfully to family interactions. The variability in settings, strategies, and session formats in music therapy highlights the flexibility of sibling and family-focused work. In the included records, there is a clear emphasis on descriptive and qualitative outcomes. The above highlights the exploratory nature of the field and the limited evidence supporting sibling involvement in music therapy, reflecting the need for more research on the topic.

DISCUSSION

This scoping review demonstrates that sibling inclusion in music therapy shows promise in a range of clinical and community settings: from hospital and hospice/palliative care settings to schools and mental health services. Descriptive accounts, which originate mostly in the USA and the UK, reveal a wide spectrum of aims to include siblings: from general family goals to sibling focused aims such as diminishing rivalry and fostering positive aspects of the sibling relationship. Intervention strategies used are just as varied: song writing, improvisation, play etc. Records describe several benefits, including more positive sibling relationships, promoted emotional expression, enhanced family cohesion, and beneficial coping mechanisms, especially in times of family crisis or transition. Despite these encouraging findings, the literature on sibling-focused music therapy remains sparse, varied and largely practice-driven. This discussion seeks to explore the existing gaps in the literature concerning

sibling inclusion in music therapy. This subsequent gap description is presented not to overshadow the findings that are already present in the literature, but to highlight areas for development in future research and practice.

Category	Most frequent occurrences in included records
Aims of sibling involvement	<p>Siblings included in general family goals⁵</p> <p>Diminish sibling rivalry⁶</p> <p>Foster (positive aspects of) sibling relationship⁷</p> <p>Personal growth and facilitating sibling interaction⁸</p> <p>Psychoeducation and improving focus child's skills⁹</p> <p>Reducing anxiety, creating a sense of normality and/or legacy and grief support¹⁰</p> <p>Support emotional expression and connection¹¹</p> <p>Logistical reasons¹²</p>
Intervention content	<p>Songwriting and song singing/legacy projects¹³</p> <p>Instrumental exploration and improvisation¹⁴</p> <p>Structured group activities: start-stop games, turn-taking, conducting, hello/goodbye songs¹⁵</p> <p>Expression by movement and dance¹⁶</p> <p>Other: music instrument teaching, collaborative band playing and performance, music listening and guided relaxation</p>
Intervention delivery schedule	<p>Often dyadic or full-family group sessions</p> <p>Siblings in 1 session or multiple sessions because of medical urgency or treatment goals</p> <p>Often weekly (30-60mins) or multiple sessions per week over a short- to medium-length duration</p> <p>Parents usually present; sometimes explicitly not (for sibling focus or respite care)</p>

Table 2: Summary table of aims of sibling involvement, intervention content and intervention delivery schedule

The four key gaps identified in the literature regarding sibling involvement in music therapy are:

- (i) Family-centred versus sibling-specific approaches: the unique dynamics of sibling relationships and parental presence in music therapy sessions.
- (ii) Clinical practice versus research: highlighting the limited representation of sibling-focused work in research studies.

⁵ (Daveson & Kennelly, 2000; Ettenberger, 2017; Heiderscheit, 2022; Knott et al., 2022; McIntyre, 2009; Pasiali, 2017, Tuomi, 2005); ⁶(Nall & Everitt, 2005; Pasiali, 2017, Woodward, 2004); ⁷(Lindenfelser, 2015; Loombe, 2017; Loth, 2017); ⁸(DeRusso, 2024); ⁹(Horton, 2004; Loombe, 2017; Loth, 2017; Pasiali, 2017); ¹⁰(Baron, 2017; Daveson & Kennelly, 2000; Diamond, 2012; Duda, 2013; Goicoechea & Lahue, 2021; Griessmeier, 2005; Hilliard, 2003; Lindenfelser et al., 2013; Nall & Everitt, 2005; Noyes et al., 2023); ¹¹(Noyes et al., 2023); ¹²(Flower, 2008; Mitchell, 2017; Oldfield, 2008); ¹³(Duda, 2013, Goicoechea & Lahue, 2021; Knott et al., 2022; Lindenfelser, 2013); ¹⁴(Allgood, 2005; DeRusso, 2024; Flower, 2008; Goicoechea & Lahue, 2021; Lindenfelser, 2013; McIntyre, 2009; Steinhardt et al., 2021); ¹⁵(Loombe, 2017; Loth, 2017; Oldfield, 2008); ¹⁶(Griessmeier, 2005; Pasiali, 2017; Steinhardt et al., 2021)

- (iii) Setting and context: the influence of geography, clinical setting, and therapeutic aims on sibling inclusion in music therapy.
- (iv) Shifting perspectives: intentional sibling inclusion in structured frameworks.

Each of these gaps is discussed below, with an emphasis on their implications for research and practice.

Gap 1: Family-centred versus sibling-specific approaches

The term 'family' is frequently used in music therapy literature, concurrent with the many results initially found in this review. However, many studies fail to differentiate between the presence of siblings or other family members. While several sources mention sibling inclusion and involvement in music therapy (e.g. Edwards & Kennelly, 2016; Tucquet & Leung, 2014; Yeow, 2018), they rarely describe details pertaining to the sibling relationship, the rationale for the siblings' inclusion, or the interventions aimed at them. Instead, the emphasis in most of these articles remains on the parent-child dyad (e.g. Haslbeck & Bassler, 2020), including the siblings only peripherally. This review identified only a limited number of records explicitly addressing sibling interactions in music therapy.

In this review, sibling interventions typically took place in group formats including entire families. The sibling relationship, however, represents a distinct and independent entity within the family structure. Unlike the hierarchical and caregiving dynamics of the parent-child relationship, sibling relationships are often characterised by time spent together, shared experiences and uninhibited expression. These qualities enable siblings to engage from a peer-like perspective, with the possibility to provide emotional resonance and support unavailable in other family dynamics. While many studies stress the importance of engaging siblings in therapy sessions, few investigate the specific therapeutic opportunities this engagement presents.

Examples from clinical practice highlight the potential of music therapy to support the sibling relationship through co-creative activities, such as musical games, instrumental exploration and improvisation and collaborative songwriting. However, such potential outcomes require a deliberate shift toward sibling-centred approaches, rather than merely incorporating siblings as an extension of the parent-child relationship. Despite this potential, research rarely focuses on the deliberate design of sibling-specific interventions. Expanding music therapy research and practice in this direction is crucial to fully realising the therapeutic potentials of sibling-specific music therapy interventions. By prioritising sibling-specific approaches, music therapy can contribute to the development and well-being of siblings, particularly in families navigating challenges.

Additionally, the role of parents in sessions introduces further complexities. In this review, parents were sometimes or always present in 19 out of 28 records. When parents opted not to attend, this was typically for logistical reasons (e.g. sessions during school hours), for respite care, or to focus on sibling dynamics. This raises the question of whether parents are always expected to be present in music therapy sessions, and what the rationale for their presence is when working with other family members. While parental presence can provide valuable context and additional support, it may also shift the focus back to the parent-child relationship, depending on how the parents engage with both the focus child and its siblings. This dynamic raises questions about the most effective ways to

facilitate sibling interactions in both the presence and absence of parents. Further studies are needed to explore how parental involvement intersects with sibling participation, which could enhance the understanding of effective family-centred music therapy interventions. Research needs to examine how sibling dynamics evolve in the presence and absence of parents and to develop interventions that prioritise sibling interactions within family-centred frameworks. By doing so, interventions can better address the developmental and emotional needs of siblings, particularly in families facing challenges. This shift would not only enrich the therapeutic outcomes for siblings but also enhance the overall family dynamic, ensuring that the sibling relationship is given the proper attention within therapeutic contexts.

Gap 2: Clinical practice versus research

A recurring theme in this review is the gap between research studies and clinical practice, particularly regarding sibling inclusion in music therapy. While clinical reports often mention sibling inclusion, research predominantly focuses on the parent-child dyad. Even when siblings are involved in research interventions, they are rarely included in data collection or analysis, leaving the sibling perspectives unexplored. For example, siblings may be mentioned in interviews with parents, yet their own voices are notably absent from the data (e.g. Hernandez-Ruiz, 2018; Ugglå et al., 2019).

Similarly, some studies or clinical descriptions mention sibling inclusion in research or clinical interventions, but do not provide sibling-specific information (Abad & Barrett, 2023; Fuller et al., 2022; Gaden et al., 2023; Lindenfelser et al., 2008; Savage et al., 2022). When siblings are included in research, such as in studies on caregiving for individuals with dementia, the focus is generally on the caregiving role or experience rather than the specific sibling relationship itself (e.g. Baker et al., 2018; Lee et al., 2022).

Much of the available literature is practice-driven and descriptive in nature, with a predominance of case studies, books and book chapters, rather than peer-reviewed research articles. Oldfield (in G. Thompson & Jacobsen, 2017) pointed out this trend, which remains evident today, particularly in the context of sibling inclusion. Clinical practice, as reflected in case studies and qualitative reports, appears to offer a richer and more nuanced description of sibling inclusion than is currently reflected in research literature. However, these clinical reports are often anecdotal accounts of sibling involvement, such as localised initiatives mentioned in conference abstracts or community news articles. While these examples suggest a wider use of sibling-inclusive practices in music therapy, their idiosyncratic and informal nature limits their application across different settings. This might explain why there were little relevant results in the database search (predominantly articles), but more results were found in the manual search (book chapters). This discrepancy is also evident in the database search results, where only three records were identified through abstract searches, seven through full-text searches, and eighteen through manual searches. In articles focused on family music therapy, siblings are often mentioned but rarely as the main focus, which explains their absence in abstracts and broader research databases.

Gap 3: Setting and context

Sibling inclusion in music therapy is influenced by geographical and contextual factors, including the clinical setting and therapeutic aims. Geographically, most records originate from the USA, UK and Australia, reflecting regional differences in practice. In the USA and UK, sibling involvement occurs often in medical or palliative care settings, where the focus is typically on coping and crisis management. In Australia, community-based music therapy models provide more inclusive approaches, potentially leading to broader sibling inclusion. Northwestern European records seem to focus more on individual or peer-based work and no records from Asia were identified, possibly reflecting the English-language bias of this review.

Sibling inclusion in music therapy is frequently tied to families facing challenges or crises, such as serious illness or bereavement. Siblings appear more prominently involved in certain settings, such as palliative care, hospice and medical settings. In these contexts, interventions often focus on legacy-building activities or bereavement groups (e.g. Hodkinson et al., 2014; Kammin & Tilley, 2013; McFerran, 2010), and to address coping and crisis management. Often, there are only a limited number of sessions in these settings. Psychoeducational interventions (e.g. Bemis, 2015) for siblings of children with medical or developmental needs, are similarly designed for sibling-only groups, addressing informational or coping needs rather than fostering joint activities with the focus child. In contrast, home-based interventions and community programs seem to include siblings more actively and more organically. For example, Savage et al. (2022) and Thompson (2017) describe music therapy sessions where activities from the sessions are repeated at home by the parents, including the siblings. However, these studies were not included in this review because of the primary focus on parent-child dynamics during the music therapy sessions. These approaches, while valuable in their own right, do not fully leverage the possible sibling dynamics that could emerge in music therapy sessions. Furthermore, the focus in current literature largely centres on crisis situations, with limited attention to the creative potential of sibling dynamics in both crisis and non-crisis settings, e.g. schools or family homes. Creativity in sibling-focused music therapy has the potential to enrich sibling relationships by emphasizing collaborative, playful, and expressive interactions. Engaging siblings in co-creative processes such as instrumental improvisation, songwriting, or shared musical games could encourage emotional expression, mutual understanding, and a sense of partnership between siblings. Despite these possibilities, the role of creativity remains insufficiently addressed in the literature, both in crisis and non-crisis settings. Non-crisis contexts, in particular, offer opportunities for music therapy to foster stronger sibling bonds and promote overall family well-being.

By shifting the focus from crisis-based interventions to opportunities for collaborative engagement, music therapy could support sibling relationships and overall family dynamics. If future research would focus on exploring creativity as a central element in sibling-inclusive music therapy, we could gain more insight into the creative potential present in all families, and how this potential could be fostered in and adapted to different family situations and contexts, for example in families with intellectual disabilities or other unique challenges. Investigating how music therapy can support siblings in diverse cultural and contextual settings would also contribute to a more comprehensive understanding of this field.

Gap 4: Shifting perspectives

The variability in intervention strategies reflects the adaptability of music therapy but also points to the absence of structural frameworks for sibling involvement. Common strategies, such as songwriting, improvisation, and structured group activities, promote interaction and emotional expression. The selection of strategies often appears context-dependent, with legacy-building and grief-focused activities prevalent in palliative care, while turn-taking and cooperative games are mostly present in early intervention programs. Psychodynamic, systemic, and cognitive-behavioural music therapy frameworks are variably employed, but their application to sibling-focused work remains underexplored. This largely reactive and context-bound approach, where siblings seem to be included mainly in response to acute circumstances such as illness, end-of-life care or practical reasons, raises an important question: are interventions designed merely to address immediate - often crisis-driven - needs, or do they focus on proactively supporting (creative) sibling relationships? While such acute circumstances often expose sibling needs, these needs are typically addressed indirectly. In many cases, the focus remains centred on parent-child dynamics, with sibling dynamics receiving little attention. To address these issues, it is essential to integrate a more intentional approach to sibling inclusion that shifts beyond incidental participation. Within systemic frameworks, a more defined sibling-focused sub-framework might be necessary to adequately address the unique relational dynamics siblings bring to music therapy. Drawing on theoretical or therapeutic models from other fields, such as systemic therapy, contextual therapy or family systems theory (e.g. Broderick, 1993; Hoffman, 1981), could provide a valuable starting point.

Transforming sibling inclusion from incidental to intentional requires a focus shift within the family music therapy community. This shift involves reconceptualising siblings as active agents in therapy, rather than passive participants, which requires greater awareness of sibling dynamics and roles in the family unit. Intentional sibling inclusion involves acknowledging their distinct perspectives, designing interventions tailored to their needs, and emphasizing their roles in family dynamics, both in presence and absence of parents. To achieve this focus shift, the music therapy field could focus on three critical strategies:

- (i) Research designs and data collections need to specify sibling input by gathering data directly from siblings themselves; particularly participatory research designs, that directly engage siblings as partners and co-researchers in both the therapeutic process and the research itself, can provide more information about possible sibling-focused interventions.
- (ii) Developing sibling-focused frameworks: theoretical models that integrate siblings' perspectives and provide information for developing interventions and techniques tailored to supporting sibling relationships.
- (iii) Emphasising creativity not just as an adjunct to coping strategies but as a central component of interventions. Creative and collaborative activities—such as songwriting, improvisation, and cooperative musical games—can foster sibling relationships. These approaches could allow music therapy to explore the potential of creative sibling dynamics in everyday life, extending beyond crisis settings. This knowledge can help identify relational strengths, which could inform early intervention strategies where needed.

Lastly, therapists' perspectives of the music therapy participants are critical in shaping these interventions. As Loth (2017) reflects on her work with triplets: "During this work, I frequently found myself thinking of the children as a pair of twins with a younger sister. [...] I wondered what difference it would make to treat them as twins plus a sibling, and how important it was to remember that they were triplets and had once shared a womb." (Loth, 2017, p.30). This underscores the need to view siblings as interconnected, emphasizing bidirectional influences and shared dynamics, rather than isolating focus children from their siblings.

Many of the records reviewed mentioned siblings only peripherally, with limited focus on their specific roles, outcomes, or experiences. In contrast, some records do describe sibling-centred practices that reflect the value of sibling inclusion in music therapy, but these often remain idiosyncratic and localised. As such, they offer promising insights, but also represent missed opportunities to build a more coherent understanding of sibling roles in music therapy. This underscores the need for structural frameworks and more systematic research into sibling involvement in music therapy. In order to address the gaps mentioned above, music therapists should embrace a more intentional and creative approach to sibling inclusion. This involves designing interventions that leverage the unique potential of sibling relationships, particularly through shared, bidirectional activities.

At the same time, sibling-focused interventions cannot be fully designed and developed without considering the broader contexts in which they occur. Sibling roles and relationships are shaped by family structures and cultural expectations. These contextual influences can significantly affect how siblings participate in and benefit from therapeutic work. There is still limited understanding of how such factors shape sibling dynamics and what this means for the development and implementation of sibling-focused interventions.

Future research could therefore explore how sibling-focused interventions can be adapted across diverse settings, cultural contexts and family structures, including those involving intellectual disabilities. Such exploration can help us better understand the specifics of certain family systems in different contexts and make us aware of how local systems shape our own clinical assumptions. A comprehensive, creative sibling-focused framework has the potential to support sibling relationships and contribute to more integrated family support in music therapy practice.

STRENGTHS AND LIMITATIONS OF THIS REVIEW

Our goal was to explore sibling involvement in music therapy. This review draws on diverse sources, including empirical studies from database searching, clinical vignettes, and manual searches. A significant strength lies in its ability to highlight the gaps between clinical practice and research, underscoring the limited but promising inclusion of siblings in varied settings. Furthermore, the inclusion of non-peer-reviewed sources, such as book chapters and conference abstracts, adds depth to the discussion by capturing practice-driven insights that seem to be underrepresented in research.

Despite these strengths, several limitations must be acknowledged. The search strategy, focused on English-language publications, may have excluded relevant studies from non-English-speaking regions, thereby limiting the global perspective of this review. Additionally, the reliance on qualitative and descriptive sources, such as case studies and clinical vignettes, restricts the

generalisability of findings. Many of these sources lack descriptions of methodologies, detailed analyses, or systematic data collection, making it challenging to draw general conclusions about sibling involvement. Lastly, the variability in music therapy approaches, settings, and target groups poses challenges to synthesizing findings and drawing broader conclusions. While this review illuminates the potential of sibling-focused interventions in music therapy, it also highlights the need for intentional research to develop these music therapeutic interventions.

CONCLUSIONS

This review highlights a significant gap in the literature: few studies have provided detailed descriptions, analyses, or evaluations of sibling-focused music therapy interventions. Most records that mention siblings do so as part of a broader family-based approach, often without detailing the specific contributions or outcomes related to sibling inclusion. Moreover, when siblings are included, it is often due to practical considerations or intuition rather than a deliberate therapeutic strategy. This lack of intentionality in sibling involvement may reflect a broader trend in music therapy practice, where the primary emphasis remains on the focus child and their parents. This review however illuminates the therapeutic potential and challenges of involving siblings in music therapy. There is a critical need for more research on sibling relationships and interactions in music therapy to support clinical practices and develop sibling-focused interventions. The current discrepancy between practice and research highlights the importance of developing and evaluating a music therapeutic framework for including siblings in music therapy. Further research is needed to provide a comprehensive understanding of how a music therapeutic framework can best support sibling relationships and interactions and how siblings can be embedded in a more structural and meaningful way in music therapy processes.

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APPENDIX

Author	Record Type	Study Type	Setting	Unit of Delivery	Aim of sibling involvement	Intervention strategies	Intervention Delivery Schedule
(Allgood, 2005)	Article	Treatment case study	USA Therapeutic day school for children with ASD Sessions at day school	Family-based group music therapy: Children (4-6yo) with primary diagnosis of ASD, Siblings welcome to attend (done in 2 families) At least 1 parent or primary caregiver present	Interventions chosen to promote joint attention, interaction among group members, self-expression and cooperative group experiences. No sibling specific aim, but parent stresses importance of sibling inclusion.	Structure music therapy sessions: greeting song, specific music activities, goodbye song, free exploration time. Instrument exercises, movement to music, rhythm-based activities, singing, improvisational music, simple folk dances, music games. Outcome: sibling inclusion important for one of four parents: sessions let sibling see 'positive things' associated with brother's ASD. Sibling shares common experiences and observes her brother successfully interacting with other children and expressing himself musically. Typically developing siblings offer same age model for both musical and non-musical behaviours and are bridge between group members.	Pre-session interview, 7-week family-based group music therapy intervention (45mins each), post session focus group.
(Baron, 2017)	Book chapter	Theoretical and Clinical work	Australia Paediatric hospital setting Sessions in patient's room	Case: Elizabeth (3yo, leukaemia), brother Ben (6yo) and grandmother Mother NP (respite)	Let family connect both musically and emotionally, reduce anxiety. Case: first time visiting hospital for brother: engaging in music making to make experience more enjoyable.	Instrument choice, song choice, instrumental play along to familiar songs, encourage all family members to select songs and instruments and sing and play an instrument. Case: active music-making, patient chooses instruments for brother and grandmother, everyone chooses song to sing. Mother joins the session while daughter is singing and reminisces. At end of session, MT encourages mother and grandmother to continue playing in between music therapy sessions and leaves instruments in room.	NS.
(Daveson & Kennelly, 2000)	Article	Case Studies	Australia Palliative care setting Sessions in patient's room	Children and adolescents in palliative care and their families Case: 12yo, younger brother involved in MT session 1 Parents NP	Provide support for family during transition, assist family to have meaningful experiences and create intimate and familiar environment for dying relative, validate and express feelings, provide opportunities for reminiscence, individual silent reflection, discussion, and self-expression.	Music-assisted creative play, parody, songwriting and selection, lyric substitution, singing, playing instruments, improvisation, guided imagery and music listening (not sibling specific). Case: Brother shares patient's musical preferences with MT and remains by bedside during session, listens to requested songs sung by MT and relates experiences and memories.	Case: 3 music sessions in 1 week, 45-60min, brother in 1 session

(DeRusso, 2024)	Master Thesis	Case study	USA NS	19yo autistic man, 14yo neurotypical brother	Explore sibling relationship and interaction within improvisational music therapy. Brother involved spontaneously, while supporting autistic sibling into entering music room.	3 improvised music experiences: accordion experience, wind chimes and clapping experience and shakers experience. Chosen for analysis because initiated by one of the siblings, through visual cues or independent physical engagement with the instrument. MT supports sibling interactions with improvised harmonic progressions and accompaniment patterns on guitar.	1 session, duration NS.
(Diamond, 2012)	Book chapter	Clinical model and case examples	Ireland School setting Location sessions NS	Primary school children (4-11yo) with trauma. Individual and group music therapy Case: boy 6yo, sister 8yo, referred to music therapy by class teachers Father absent in family; older siblings and mother NP	Case: offer siblings a safe space where they can explore experienced issues; enable clients to think beyond current difficulties, let them be children with the same hopes, dreams and aspirations as their peers. Siblings explore and express anxieties, realise they are not in isolation.	Service not described as 'therapy' but as 'creative programme where children could work individually or in small groups using music for self-expression and to develop new skills'. Vocal or instrumental improvisation not in early sessions as too challenging. Structured activities to engage and develop social skills: playing in a band, music and drawing, creating musical stories and characters, song parody (about day-to-day activities) and (autobiographical) songwriting. Case: gradually as siblings begin to feel safe with the MT, they create music and songs which reflect not only their anxieties but hopes for the future.	Schools received MT service of a half/full day per week during the academic year.
(Duda, 2013)	Article	Literature review with case examples	USA Paediatric palliative care Sessions in hospital	Case L.A.: siblings of dying patient Parents NS	Provide creative opportunities for expression, create tangible representation of a memory, legacy building.	Songwriting, copies of the song for all family members to sing together for L.A. to say goodbye.	1 session, duration NS
(Ettenberg et al, 2017)	Article	Practice model and case vignettes	Colombia Hospital setting (NICU) Sessions in NICU	Case: NICU baby Sebastian and sister Juliana Parents present. Sister NP in sessions, but active agent	Important to involve siblings from a family-centred perspective.	Sister cannot visit brother in NICU. MT proposes sister to write welcome letter for baby. Together with MT, parents structure lyrics according to sister's letter and improvised melody provided by MT. Recording is made for sister. In further sessions, MT and parents work on song and incorporate sister's suggestions. MT edits video of song and gives it to family upon discharge.	Sessions offered on daily basis, duration NS.
(Flower, 2008)	Book chapter	Clinical work	UK Hospice setting	Case: 6yo Meh-Noor, parents, 2 older (school-age) and 1	Case: MT at home because of MN's interest in music, focus on healthy	Case: familiar songs and improvisations developed from songs, exploring instruments (both from MT and family's own). Same songs and structures (recapitulation of sessions with Meh-	1 session with MN and family members, focus on MN. After her death, 1

			Sessions in family home	younger (toddler) siblings Parents present ('oversee')	creative time together with family members. Siblings present because at home during 1 st session, in 2 nd session siblings deliberately included.	Noor) in both sessions. Importance of balance between structure and flexibility. MT takes less central position, offering musical equipment, structures and own musical self, to be appropriated by family. Also, possibility of direct contact (musical or verbal) with different family members.	session with family, duration NS.
(Goicoechea & Lahue, 2021)	Article	Case studies	USA Hospital setting Sessions online	Case: 2 brothers of deceased sister Parents NP	Strengthening coping skills, increasing emotional expression and grief/ legacy support.	Facilitate verbal expression, therapeutic instrument instruction (MT teaches brothers guitar in virtual setting) in order to move towards legacy songwriting. Brothers alternate roles: one brother works with MT, another brother supportive role.	Multiple telehealth sessions, weekly, 1 hr
(Griessmeier, 2005)	Book chapter	Case study	Germany Palliative care setting Sessions in MT room, isolation unit, outpatient clinic	Pedro (10yo, leukaemia), younger brother Carlos Mother present in all sessions, brother and other family members in several sessions 3 group sessions (members NS); 22 individual sessions with P. 25 sessions with family members during 6 months before death	Brother's presence encouraged by MT to unite scattered family. Brother joins sessions when possible during last 6 months, cousin and various other family members join sessions. Brother loves sessions because of being together with P in a normal way, without being constantly reminded of illness.	Sessions with brother in hospital: Dancing to P's music, listening to P and his favourite CD's, play along to CD's, singing and playing familiar songs with family members. Audio and videorecording the sessions important to the family. Last session at home with family unit, singing Christmas carols.	50 sessions in 2 years, varying frequency, duration NS.
(Heiderscheidt, 2022)	Article	Feasibility and acceptability study	USA Hospital setting Sessions in patient's room	10 hospital patients 6–13yo and their family (of which 5 families with siblings who engage in active music making)	Siblings engage in family directed active music making intervention for enjoyment, relaxation, management of stress, anxiety, nausea and discomfort, soothe patient, help patient sleep, provide distraction,	Instruments that require no training to play (reverie harp, egg shakers, buffalo drum, ocean drum) and have a pleasing and musical sound. MT videorecords instrumental music tracks that incorporate rhythm patterns and a variety of tempos played on various instruments. MT gives instructions on how to access and use videos and instruments. Participants' choice about when and how to use the instruments and make music, as well as who engages in making music.	2x/week: check in of MT. Materials available to patients 24h/day and remain in patient's room throughout inpatient stay (up to 60 days).

				At least one parent present	managing boredom and as a way of engaging with one another.	MT checks in and provides assistance when needed (harp tuning, check materials). MT talks with patient and family about if, and/or how they use instruments and video tracks and to collect journal forms.	
(Hilliard, 2003)	Article	Case studies	USA Palliative care setting Sessions in family home	2 cases involving siblings of patients in paediatric palliative care Parents present	Case S: facilitate family interactions and provide opportunities for positive interaction. Case C: increase quality of life, provide positive family interactions, decrease anxiety, encourage each family member in the music-making process, create sense of normalcy.	Case S: live requested song singing with guitar accompaniment by MT, opportunity for siblings to write songs and sing them to patient, offer parents opportunity to see children smiling and having fun at challenging time. Case C: structured activity led by MT. Sing-along with family, using patient's preferred music. During singing, MT gives each family member a musical instrument to play. MT incorporates each family member's name into song.	Case S: 2 months, weekly, duration NS Case C: Number and duration NS, weekly
(Horton, 2004)	Newspaper article	NS	Scotland Recreative setting (pre-school play group) Location NS	Children with special needs and their siblings Parents sometimes present; Group session with other families Case: Jamie (ASD), younger brother Nathan, and mother Louise	Use music for non-musical aims, e.g. help develop children's communication skills and self-expression, improving language and social skills. Siblings encouraged to come along because more beneficial to children with special needs.	Improvisation, songs with actions.	Several years Number, frequency and duration NS
(Knott et al., 2022)	Review	Synthesis of literature review, practice documents and survey	USA Hospital setting Location sessions NS	Siblings of children with oncological and/or haematological conditions Parents and treatment team members sometimes present	Adhere to PSS10: sibling support as a standard of care Engage family in music-making to encourage family cohesion and well-being and manage stress, bereavement care.	Music making, singing, create legacy projects (heartbeat recordings, personal songs), other strategies with siblings NS.	Provide sibling support through scheduled group sessions and involve siblings in patient-directed sessions. Case: 2-3 sessions/ week, duration NS

				Case: 7yo John, mother, 2yo sister involved in music therapy, father NS	Case: when sister is present, included in sessions to encourage sibling engagement and promote support and belonging in care environment.		
(Lindenfelser et al., 2012)	Article	Mixed methods study	USA & Australia Paediatric palliative care (PCC) setting Sessions in family home	14 families receiving home-based PPC for child Parent present in family home during sessions Siblings choose whether and how they join the sessions	Explore benefits of music therapy beyond the patient to the family. Siblings most often actively engage in creating the positive experiences shared during music therapy. No sibling specific aims, but parents stress importance of sibling inclusion (goals determined with parents, focus remains on palliative child).	Music making with instruments, singing, song writing, song lyric analysis, music listening, music and movement, guided music relaxation and imagery. Outcome: music therapy fostered positive experiences, facilitated communication within some families, provided opportunities for expression, choice and control, helped gain better understanding of each other, facilitated feelings of connectedness and family inclusion.	5 weekly music therapy sessions, 45-60mins
(Lindenfelser, 2013)	Book chapter	Theoretical work and clinical examples	USA Paediatric palliative care setting Sessions at hospital, home, hospice or school	Siblings and family members of children in paediatric palliative care	Provide space for and validate feelings/wishes/fears/joy s of siblings, play together with sick sibling and let siblings feel helpful.	Prepare the space, assessment in beginning of session. Live and recorded music listening, song analysis, music-guided imagery for relaxation, instrumental and vocal improvisation, storytelling and symbolic play, song singing and songwriting. Cases: involving siblings in selecting recorded songs for sick sibling, engaging siblings in vocal/instrumental improvisation or storytelling to express emotions, songwriting, playing together with their sick siblings and exploring musical parameters (loud-silent, turn-taking).	NS.
(Lindenfelser, 2015)	Book chapter	Clinical work, case study	USA Palliative care setting Sessions in family home	3yo David (medical condition, wheelchair), older brother Peter (P) and parents	Aim of mother: improve family bonds, provide opportunity for engagement and interaction between brothers, understand D's ability to tolerate and enjoy music.	Assessment of D's physical and developmental state and family's emotional state and update of previous week. Interventions: improvisation, re-creative and neurologic music therapy methods. Session 2: bag with instruments, songs, turn-taking, independent play and perform, play together (MT accompanies with voice and guitar), play with musical parameters (volume,	5 sessions over 7-week period, weekly if possible, duration 1hr.

				Mother present in all 5 sessions, father in last 2 P in last 4 sessions (request from MT; after 2 nd session, on P's request)	Because of MT and responses and actions of brothers, P more involved by parents in D's care and routines.	start-stop games), ending song 'if I were a butterfly' with movement. Session 3: instrument play (P chooses instrument for D), familiar songs, improvised songs on guitar (MT asks P questions about wishes and fears concerning D), reflection with mother after session. Session 4: P plays piano for D, Family sings and hums melody, instrument teaching (D instrument to enable him to play along if desired), MT and P piano improvisation, mother holds chimes for D. Session 5: P&D play together on autoharp, MT supports D; familiar songs with accompaniment of brothers on autoharp, song 'if I were a butterfly' (P assists mom to help D move body to the lyrics), reflection.	
(Loombe, 2017)	Article	Case study	UK Child Development Centre (CDC) Sessions at CDC	Harry (4yo), baby sister and mother in 2 sessions, entire family (H, parents, older and younger brother, baby sister) in 'a few' sessions Parents present	Support sibling relationship, support H in knowing how to respond to baby sister and how to communicate. Making siblings aware of each other, listen and take turns.	Structured sessions: hello and goodbye songs, space for free vocalizing or improvisation. H encouraged to be the expert: show siblings instruments and activities and include siblings in his sessions. Siblings enjoy sharing in positive play (using names, musical games, show songbook to siblings, turn-taking, choosing instruments for each other). Family and MT play as a 'band' together. Father asks for musical strategies to utilise at home, to encourage boys playing together.	Sept 2014 – Sept 2016. 2 assessment sessions, weekly music therapy sessions (30mins + review with parents).
(Loth, 2017)	Article	Case study	UK Community music therapy clinic Sessions in clinic	Triplets (one, Emma, 2yo, has special needs) and mother Mother present, father NP 7 sessions with all triplets, 1 only E and mother. Continuation only with mother and E (focus on relationship)	Aim of mother: have time alone with E during music therapy but also involve all 3 siblings to learn how to play together; mother herself learn how to deal with them and manage their behaviour better.	Structure: hello song and group musical activities accompanied by songs: playing on (percussion) instruments, focus on turn-taking. Structured sessions: simplified activities, clear boundaries in using instruments (letting siblings choose instrument for each other, learning to share), games to channel siblings' competitiveness (e.g. 'start-stop game'), children assign themselves to 'their' seat (physical containment by e.g. 'marching around the room and find your chair' activity), playing on large instruments to share rather than individual instruments.	8 sessions in 3 months (7 with siblings), duration NS
(McIntyre, 2009)	Article	Case studies	Australia Inpatient mental health service	2 cases with siblings Parents present	Focus on interactions between all family members, on their ability to play together and	Rhythmic imitation and improvisation, playing popular songs in specific arrangement, free group improvisation, duet style improvisation on keyboard with MT, group play on hand drums	2-3 sessions during family's 1–2-week admission

			Sessions in inpatient unit	Case Escada: boy (10yo) with mental health issues, parents and 5 older siblings, 2 family sessions Case Benjamin: boy (14yo) with severe depression, mother, sister (15yo) and brother (7yo), 1 session	participate in activities together, and identify key issues that are affecting the system.	(with MT changing rhythms and dynamics), recording improvisation on CD. Case E: Group play on hand drums. Improvisations recorded on CD and given to family. Brother describes importance of music therapy session for family. Case B: group play on hand drums, MT directs play. 1-on-1 improvisation with MT on piano. MT asks sister and mother to verbalise experience.	(Case B: 1 session), duration NS.
(Mitchell, 2017)	Article	Case study	UK Thomas's Fund charity Sessions in family home	Case: Megan (2yo) with complex needs, 4 siblings (preschool age) Mother present in most sessions. Initially sessions for M, siblings join in in home context during school holidays	Occasionally siblings are encouraged to attend sessions with pre-school aged children. Case: sibling presence as compromise in home setting, MT focuses on what M gains from positive interaction with her family.	Structured sessions to enable M and each sibling to be heard. Elder sibling gives MT M's preferred songs, all siblings like to form a 'band'. When older age: turn-taking, choosing instruments, help M by supporting her with instruments and allowing space for her.	Assessment + 10 weekly sessions + rereferral for ongoing sessions until present, duration NS.
(Nall & Everitt, 2005)	Book chapter	Clinical work	UK Hospice setting Sessions in family home	Case 1: Ollie (almost 2yo), brother Edward (age NS), mother NP (respite) Case 2: Jessica (11yo) and two younger sisters (Hollie and Annie)	Case 1: improve quality of sibling relationship and address sibling rivalry, encourage turn-taking and sharing, special time for brothers to play and be together as equals. Case 2: (pre)bereavement support.	Case 1: vocalising, children's songs and musical games with opportunity to play solo, letting brothers choose instruments and activities for one another, dancing, explore instruments. Case 2: take turns playing and listening, singing and playing favourite songs, playlist making, songwriting for deceased sister.	Case 1: 34 sessions with brother over period of 61 weeks, duration NS. Case 2: 2 sessions with H and A (J respite care). After J's death, joint sessions with H and A at school, duration NS.
(Noyes et al., 2023)	Article	Case report	USA Palliative care setting	12yo brother of Riordan (10yo) in palliative care	Support strengths and love within family, help brothers find new ways of connecting by 'doing', give opportunities for	Express experiences through supported music expression, rhythmic interventions, song singing, sharing, and song writing to express what they need individually while the other members and MT hold the space.	Number and duration NS, initially fortnightly then weekly sessions during final months.

			Location sessions NS	Entire family unit present in all sessions	meaningful contribution, connection and memory making, enable expression of experiences.		
(Oldfield, 2008)	Book chapter	Clinical work	UK Outpatient Child Development Centre Sessions in CDC	Pre-school aged children and parents in sessions, younger siblings and grandparents welcome (sessions during day, often no older siblings present in sessions) Case: Nick (3yo, developmental delay, ASD), Jenny (2yo) and mother present, father NP. J on 'special outing' with father once per month to let N and mother work alone with MT	Aim case discussed by MT and mother: focus in process remains on N. Sibling specific goals: provide opportunities for N and J to have fun together and with mother. Music as a means to an end. J initially included in MT because no childcare available during session with N.	Clear and predictable (flexible) structure in sessions with room for siblings' choices and spontaneity, review with mothers after every session Case: hello and goodbye songs, singing familiar songs, explore instruments, siblings play together, J being asked to help out N. Middle sessions: encourage N to keep playing, MT or mother support J in playing, musical games with N in control. Often N interested through J's involvement in playing, siblings attuned to each other's mood states. End sessions: imitation, communicating through music exchanges (expected by N), J not only supporting N's playing but active participant. Focus on turn-taking, with MT working with one sibling and mother with other.	Case: 17 months, frequency and duration NS Sessions end when Nick goes to school full-time, receives individual music therapy there.
(Pasiali, 2017)	Book chapter	Theoretical and clinical work and case vignettes	USA Community action agency Case sessions in family home	Case: Henry (5yo, behaviour issues), 2 siblings (9yo and 12yo), mother, father 1 session: everyone, 5 sessions: mother and/or father, Henry and siblings, 3 sessions: only Henry and father	Case: help family understand H's needs and gain insight in how to improve family's interpersonal communication, referred to music therapy because of H's behaviour problems and sibling rivalry. Playing music gives H the opportunity to interact with his brother.	(Un)structured and thematic improvisations with or without keyboard supportive playing, musical performance (ensemble pieces), movement (with musical instruments and props), singing or humming songs while patients play instruments, song discussion (selected by MT or family), songwriting (original or pre-existing melodies), jamming (with or without song requests), music-assisted relaxation. Parent consultations during sessions or by email. Case: Jamming as opening ritual (color-coding, song charts), performing pre-composed arrangements with MT conducting, improvisation (MT models for brothers, brothers imitate MT), movement experiences targeting body awareness, sensory integration and regulation using props, experimenting with rhythmic chants, relaxation exercises as ending routine with short reflection (complete statements that promote intimacy).	Case: 9 sessions (of which 6 with siblings), frequency and duration NS.

(Steinhardt et al., 2021)	Article	Qualitative and explorative pilot study	Norway Paediatric palliative care setting	10 families with children (0-16yo) admitted in hospital-at-home	MT and family define treatment goals together with multidisciplinary team.	First session: assessment, establish relationship. Expressive and receptive methods including songwriting, instrument training, improvisation, verbal processing, music listening, guided relaxation and imagery, singing familiar and preferred songs, making playlists, dancing on recorded music. Participate using guitar, drums, songs or dancing.	Max. 5 session, 1-2 sessions/ week, 45min
			Sessions in hospital-at-home	Focus on palliative child, siblings and other family members encouraged to participate in sessions	No sibling specific aim, but parents stress importance of sibling inclusion.	Outcome: MT serves as a bridge to normality and having fun, provides a safe and stimulating platform for patients to interact with their healthy siblings, offers feeling of connectedness.	
				Sometimes nurse present in sessions			
(Tuomi, 2005)	Conference proceeding	Clinical model and case study	Finland Foster care institution	Children (1month-8yo) from foster and adopt families	Support child and family at point of re-placing, transfer institutional knowledge to family and support family interaction by functional means with help of music and arts. Parents stress importance of sibling inclusion.	Singing, playing with instruments and toys, music listening, working with pictures, drama, moving and dancing, discussion.	2-13 sessions in model, mainly with child and primary caregiver, weekly.
			Sessions on ward + in music therapy room	Case Thomas (14months): individual music therapy followed by couple music therapy and 3 sessions with entire foster family (mother, father, 10yo boy, 8yo boy, 5yo girl)	Case: pay attention to the family as a whole but also to everyone as an individual and important part of the family, 'doing something together'.	Case: discussions with foster mother important: discuss reactions of other children but focus on T and his development. Family sessions include working with different roles inside family (both existing roles and changes T brought into system); roles are reflected by picture making, improvisational playing, recording and listening, contact making-plays and discussions. MT interprets family improvisations.	Case: 3 sessions with family at beginning, middle and end of the couple process, 45min.
						Outcome MT: decreased jealousy of siblings.	
(Woodward, 2004)	Article	Clinical examples	UK Resources for Autism charity	Case 3: 5yo boy with Asperger's Syndrome and 3yo brother referred by mother	Case aim: diminish sibling rivalry, support mother in ability to parent children.	Case: musical games (NS). MT encourages reflection between siblings about session events. MT and mother review sessions over the phone. In later sessions, MT and mother take less active role.	Case: 4 months, ongoing at time of writing Frequency and duration NS.
			Location sessions NS	Mother present			

Table 3: Data analysis of included records (NS= not specified; NP= not present; MT= music therapist; names are abbreviated to initials after first use)

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Ελληνική περίληψη | Greek abstract

Συμπερίληψη αδελφών στη μουσικοθεραπεία: Μια ανασκόπηση πεδίου

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ΠΕΡΙΛΗΨΗ

Η παρούσα ανασκόπηση πεδίου εξετάζει την τρέχουσα έρευνα και την κλινική πρακτική σχετικά με την ένταξη των αδελφών στη μουσικοθεραπεία, διερευνώντας τον τρόπο περιγραφής της συμμετοχής τους, τα πλαίσια εφαρμογής και τους αντίστοιχους στόχους. Οι σχέσεις μεταξύ αδελφών είναι ουσιαστικές για την ψυχοκοινωνική ανάπτυξη κατά την παιδική ηλικία και την εφηβεία, ωστόσο η συμμετοχή τους στη μουσικοθεραπεία παραμένει ανεπαρκώς διερευνημένη σε σύγκριση με τις δυναμικές γονέα-παιδιού. Αυτή η ανασκόπηση συμπεριέλαβε μουσικοθεραπευτικά μοντέλα, προγράμματα ή παρεμβάσεις που καταγράφονται στη βιβλιογραφία και εντάσσουν αδέλφια μικρότερης ηλικίας σε συνεδρίες ή διαδικασίες μουσικοθεραπείας, αποκλείοντας καταγραφές που επικεντρώνονται αποκλειστικά στις δυναμικές γονέα-παιδιού. Πραγματοποιήθηκε εκτενής αναζήτηση το 2024 σε ηλεκτρονικές βάσεις δεδομένων (Scopus, MEDLINE/PubMed, PsycArticles, Web of Science, Embase, ProQuest) και σε τρία περιοδικά (*Journal of Music Therapy*, *Nordic Journal of Music Therapy*, *British Journal of Music Therapy*). Οι λέξεις-κλειδιά περιλάμβαναν «Αδέλφια», «Αδελφός», «Αδελφή», «Οικογένεια» και «Μουσικοθεραπεία». Είκοσι οκτώ αρχεία πληρούσαν τα κριτήρια ένταξης. Η ένταξη αδελφών εμφανιζόταν συχνότερα σε ιατρικά και παρηγορικά πλαίσια, με στόχο την ενίσχυση των σχέσεων μεταξύ αδελφών, τη συνοχή της οικογένειας και την προαγωγή δεξιοτήτων αντιμετώπισης. Οι στρατηγικές παρέμβασης περιλάμβαναν σύνθεση τραγουδιών, αυτοσχεδιασμό, δομημένες ομαδικές δραστηριότητες και έργα κληρονομιάς. Οι συνεδρίες διέφεραν ως προς τη συχνότητα και τη διάρκειά τους, με τα πλαίσια εφαρμογής να κυμαίνονται από οικογενειακά σπίτια έως νοσοκομεία. Παρότι τα ποιοτικά δεδομένα ήταν πλούσια, τα ποσοτικά στοιχεία ήταν περιορισμένα. Τα ευρήματα ανέδειξαν τη δυνατότητα της μουσικοθεραπείας να ενισχύει τις σχέσεις μεταξύ αδελφών, να μειώνει τον ανταγωνισμό, να διευκολύνει τις δεξιότητες αντιμετώπισης και την έκφραση συναισθημάτων και να ενισχύει τη συνοχή της οικογένειας. Ωστόσο, η συμμετοχή των αδελφών συχνά συνέβαινε περιστασιακά. Εντοπίστηκαν τέσσερα κενά: (i) προσεγγίσεις με εστίαση στην οικογένεια έναντι προσεγγίσεων ειδικά για αδέλφια· (ii) απόκλιση μεταξύ έρευνας και πρακτικής· (iii) επιρροές του εκάστοτε πλαισίου· (iv) μεταβαλλόμενες οπτικές. Η αντιμετώπιση αυτών των κενών απαιτεί την προτεραιοποίηση των αδελφών ως ενεργών συμμετεχόντων και την ανάπτυξη σκόπιμων, δομημένων προσεγγίσεων, υποστηριζόμενων από ερευνητικά δεδομένα.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

μουσικοθεραπεία, αδέλφια, αδελφός, αδελφή, οικογένεια

ARTICLE

Music Time-Out with digital voice assistant: Design of a music intervention to complement psychotherapeutic/psychosomatic treatment

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ABSTRACT

This paper presents the design and explanatory approach of a digital music intervention, termed 'Music Time-Out,' that aimed at enhancing psychosomatic post-treatment care for patients with psychosomatic disorders after a hospital stay. By utilizing a digital voice assistant (DVA), the intervention facilitates attentive music listening, fostering self-awareness and emotional regulation. Grounded in theory and research from psychotherapy, music psychology, and music therapy, the DVA guides patients through relaxation, imaginative exploration, and emotional reflection. Potential benefits in terms of self-care are weighed against the technology-related challenges and data handling. Further clinical application and evaluation are proposed to assess therapeutic effectiveness and user experience.

KEYWORDS

outpatient aftercare,
music intervention,
digital voice assistant,
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INTRODUCTORY NOTES

This article is based on an interdisciplinary project that combined music therapy, psychology, and engineering sciences/informatics. The project aimed to develop a music-based intervention to complement the aftercare of patients¹ following treatment at a psychosomatic hospital. This intervention, termed 'Music Time-Out', involves listening to music while engaging in interactive activities with a digital voice assistant (DVA), which encourages reflection on the inner processes and imagery evoked by the music. This article focuses on providing a description and detailed explanation of the theoretical approach that forms the foundation for developing and implementing the intervention in clinical practice.

When designing a music intervention, guiding principles include the specific care needs of the clientele, the intervention's goals, the specific contextual conditions including the national healthcare system, and finally ethical criteria. This means that a large number of decisions must be made consciously during the development phase, i.e. before clinical application and evaluation. Clinical and therapeutic experience as well as theoretical considerations are required to justify the chosen setting, procedure, indication, and objectives, and to assess possible risks.

Theories and research findings relevant to the 'Music Time-Out' originate from various fields, including psychotherapy and music therapy, both based on psychodynamic principles, as well as music psychology. Each of these fields is large, complex, and heterogeneous. Therefore, it is necessary to select suitable theorems and research findings. Due to the interdisciplinary nature of the project, it is unrealistic to expect this selection to be exhaustive within the aforementioned domains or to be fully comprehensible to their specialists.

The combination of the individual components of 'Music Time-Out' is not arbitrary; it follows the criteria of relevance, consistency, transferability, and application-related plausibility. The aim is to achieve a certain degree of systematic coherence and construct validity. However, permeability is also a feature of a new concept because it allows new perspectives or research results to be incorporated into the explanatory approach at a later stage. The fundamental assumptions related to the scientists' preferred theoretical orientation and the use of primary sources representing original ideas provide stable points of reference for comparison with other concepts. In addition, a careful review of current sources and research findings was conducted to determine their potential for clinical application.

CLINICAL APPLICATION AREA

Target group: Persons with psychosomatic disorders

Psychosomatic disorders, or according to international terminology, medically unexplained physical symptoms (MUPS), are any organ damage or disturbances in physical functions whose development

¹ The term 'patient' is used throughout this article. It does not diminish those affected by a psychosomatic disorder; rather, it acknowledges their suffering from symptoms and their need for support. Using neutral terms from engineering sciences such as 'user' or 'listener' would not reflect the clinical perspective of this article. Furthermore, the term 'client' is inappropriate, as people cannot be clients of a DVA.

or progression (onset, maintenance, and deterioration) are strongly influenced by psychological or psychosocial factors. Diagnostically, there are indications of altered body perception, vegetative dysregulation, neuropsychological stress symptoms, psychological symptoms, altered processing and behaviour patterns, and abnormalities in the individual's socialisation or biography. The life history and behaviour of patients regularly show characteristics and patterns of unfavourable stress-related biographical influences like emotional or physical neglect and/or abuse in childhood or experiences of violence, which make the psychological and psychosomatic complaints equally plausible (cf. Egloff et al. 2018). Those affected have a deficiency in basic skills, such as the ability to put inner conflicts and emotional states into words (symbolisation) or to perceive their own and others' emotional states (alexithymia; Binneböse et al., 2022).

Inpatient psychotherapy treatment of psychosomatic disorders

In Germany, the inpatient psychotherapy treatment of persons with severe psychosomatic disorders lasts 6-12 weeks and typically involves a multimodal treatment approach (Spitzer et al., 2016). This may include music therapy (Schmidt & Kächele, 2017), including music-imaginative methods like Guided Imagery and Music (Liesert, 2018) or Music-imaginative Pain Treatment (Glomb et al. 2022; Metzner, 2021; Metzner et al., 2022).

Music therapy is not alone in its use of mental imagery, as it is also used in psychotherapy (Dorst & Vogel, 2014). According to a psychodynamic theoretical approach, imagination has (among other things) an expressive and clarifying function. Due to its aesthetic potential, with aspects of excess meaning, product character, and flow and playfulness, mental imagery is accompanied by a revitalisation and a therapeutically promoted self-contact: an incentive for self-exploration and self-experience, the mobilisation of strengthening early kinaesthetic experiences, and the exploration of previously unexperienced ego possibilities (Bahrke & Nohr, 2023). Through the subsequent detailed verbalisation in therapeutic conversation, emotions, conflicts, relationship desires, and typical defence mechanisms, but also particular ego strengths and regulatory abilities come to consciousness. This describes a process towards an ever-increasing ability to distance oneself from the pressure of a given situation, comparable to what Fonagy and colleagues (2004) have termed mentalised affectivity.²

From the above, it is apparent that the overall aim of multimodal inpatient treatment is not solely to reduce symptoms, but also to encourage self-regulation in daily life, changes in lifestyle, and (interpersonal) behaviour (Haase et al., 2008). The change in the pathology of conflict is an essential aspect of psychotherapeutic success (Henkel et al., 2024).

Outpatient aftercare for psychosomatic patients

After discharge from a psychosomatic hospital, a structured outpatient aftercare would ideally be offered to consolidate the empirically proven successes of residential treatment (Valdes-Stauber et al., 2020) and continue the change processes initiated during hospital stay. The aim is not primarily

² The highly complex discourse on mentalisation in contemporary psychoanalysis cannot be explored in depth here. As introductory reading for music therapists, the article by Hannibal & Schwantes (2017) is recommended.

to promote well-being, but to help patients overcome the challenges they face in everyday life. In particular, aftercare aims to provide assistance in regulating emotions, affirming a sense of self, reducing depression, and overcoming feelings of isolation, as well as regulating personal relationships. Returning to working life as soon as possible is also one of the central issues because of the growing threat of permanent job insecurity. The challenge is that during their recovery process, patients have to cope with rapid structural changes in the world of work, such as technological advances and/or accelerated work processes. These changes increase the demands placed on self-regulation, flexibility and mobility (Binneböse et al., 2022).

Aftercare, however, is not available in all regions. To compensate for gaps in outpatient treatment, there is an increasing tendency to develop hybrid or purely digital health services (Berger et al., 2024; Ebert & Baumeister, 2023). As well as evaluating general success factors identified by Schramm and Carbon (2024) like patient-centred design, efficiency of application, user-friendliness, compliance with data protection, and information security regulations, researchers have conducted a wide range of studies on the application and impact of these offerings. Support services with digital voice assistants (DVAs) that are specifically oriented towards psychotherapy show a broad variety regarding objectives, therapy forms, technologies, and level of implementation (Siegert et al., 2023). This is an indication that the entire field of e-health applications is still in the pilot phase.

When it comes to music therapy, outpatient follow-up treatment options are extremely rare in Germany. A music therapy programme for tinnitus patients at Rostock University Hospital is an exception (Körber et al., 2023). Normally, outpatient music therapy must be paid for privately, which only a small percentage of patients can afford. A literature search on various databases (e.g., PSYINDEX, MEDLINE, and PUBMED) regarding the use of music within follow-up psychotherapy typically financed by health insurances yielded no results.

A growing interest in internet-based, self-help music interventions as an adjunct digital therapy by caregivers or healthcare providers, as well as music streaming services and software development companies (Schriewer & Bulay, 2016; Gadd et al., 2020) were the starting point for the interdisciplinary collaboration outlined in this article.

FUNDAMENTAL PROCESSES AND FUNCTIONS OF LISTENING TO MUSIC FOR 'MUSIC TIME-OUT'

Music can have positive health effects for both healthy individuals and those with various physical, mental, or social issues (Bernatzky & Kreutz, 2024; MacDonald et al., 2012). A wide range of theoretical explanations have been proposed to address the evolutionary, biological, physiological, anthropological, psychological, social, and socio-cultural dimensions of music (Fancourt & Finn, 2020; McCrary et al., 2021). In particular, listening to music triggers complex interactions between multiple mechanisms involving different neural networks. These include basal processes such as arousal and entrainment, as well as mental imagery, musical expectations, and aesthetic judgements (Juslin, 2013, 2019; Juslin & Västfjäll, 2008). Researchers have increasingly become interested in the internal connections and interrelationships of these multidimensional processes (e.g., Baltazar, 2018; Juslin et al., 2022).

Bridging music as an everyday resource and Music Time-Out as an after-care application

Any aftercare must be integrated into everyday life and therefore be based on everyday behaviour. For this reason, the concept of 'Music Time-Out' initially proceeds from the basic assumption that listening to music has an important place in many people's everyday lives (DeNora, 2000).

The influence of individual and situational variables on music listening in daily life varies considerably (Greb et al., 2018). But regardless of age and gender, listening to music has three key functions: (1) to regulate arousal and mood/emotion, (2) to become more conscious of oneself, and (3) to express social connectedness (Schäfer et al., 2013). These functions should be viewed dimensionally. The fact that healthy people intuitively use music as a social surrogate when feeling sad (Schäfer et al., 2020), for example, shows parallels between music listening and interpersonal emotional regulation strategies. Listening to music is chosen more often than contacting a good friend (Kahn et al., 2022).

Music components such as tempo, dynamics, pitch, rhythm, harmonic structure, and/or instrumentation can contribute to the patient's arousal, mood or imagery. However, there are no monocausal mechanisms as expectation, predictability, and familiarity mediate the subjective experience (van den Bosch et al., 2013).

Determination of the locus of emotion

When people pay attention to their emotions while listening to music, they recognise them as either induced or expressed by the music itself (Gabrielsson, 2002). This is a decisive factor in the 'Music Time-Out' intervention because, from a psychodynamic perspective, it corresponds to two modes of mentalisation: the psychic equivalence mode and the reflective mode (Allen & Fonagy, 2009). Mentalisation is defined as the imaginative mental activity through which one attributes feelings, actions, and intentions to oneself, other people, or phenomena in the external world. Psychic equivalence describes mental activity when the external world – in this case, the music – and the patient's internal world converge. In reflective mode, the patient distinguishes between the emotional expression of the music and their own state of mind. In short, perceiving music as sad does not automatically make the listener feel sad (Eerola & Peltola, 2016).

With practice, listeners can determine the locus of emotion, shifting between recognising music as an object outside themselves and focusing on the feelings, images, and memories that it inspires. A side effect that may be relevant for psychosomatic patients is that psychophysiological reactions vary depending on the locus of emotion (Merrill et al., 2020).

Mental imagery during music listening

The 'Music Time-Out' is designed to stimulate creative internal processes in the form of mental imagery that arise spontaneously, which is termed music-guided imagery. While listening to music, the dynamic character of the music influences the vividness and affective quality of mental imagery, but not the actual content (Taruffi et al., 2019). Music-guided imagery activates areas of the brain

that intersect with those involved in the emotional processing of events (Ballan & Abraham, 2016; Holmes & Matthews, 2010; Koelsch, 2015).

Mental imagery (in general) is multimodal and includes bodily sensations, movements, actions, and events experienced (Nanay, 2018; Taruffi & Küssner, 2019). The changeable, sensory-perceptual, and/or kinaesthetic (Leikert, 2011) symbolisations develop from early childhood and are connected to an individual personality structure and life history, as well as to a particular context. These insights are used in several music therapy methods, for example in analytic music therapy (Priestley, 1994) or in Guided Imagery and Music (Bonny, 2002; Bruscia & Grocke, 2002). In these methods, the imagery and emotions arising from the music are discussed in therapeutic conversations, which offer the therapeutic benefits outlined above.

DESIGN OF THE MUSIC TIME-OUT

'Short music journeys'

The "Music Time-Out" is based on the 'short music journey' model (*korta musikresor*, KMR; Kaestle & Müller, 2013; Wärja, 2015), a resource- and solution-oriented approach, originally developed as a complementary intervention in the context of psychotherapy, coaching, or counselling. KMR as an aftercare intervention has proven effective in a randomised controlled study with cancer patients (Wärja, 2018), helping to reduce anxiety/depression and improve quality of life.

The KMR process begins with a short preliminary conversation. Once the therapist has checked the patient's current mental state, they agree on a thematic focus. The therapist selects a suitable piece of music of around 4 minutes and then leads a short relaxation exercise before the patient embarks on the 'imaginative journey' with a thematic stimulus and the music. After the music finishes, the therapist invites the patient to return to the here and now, and to respond to the experience – first visually, by drawing a mandala, and then verbally, talking with the therapist about its meaning for the patient's life.

Music is seen as having a co-therapeutic function in this process (Wärja & Bonde, 2014). To address the different degrees of intensity of mental processes, pieces of music used in KMR are assigned to the categories 'supportive' (e.g., secure, holding), 'mixed supportive' (e.g., opening, stimulating), and 'challenging' (e.g., exploring, discovering).

The use of a digital voice assistant to support music listening

The starting point for the design of the digital assistance was insights from a qualitative study on the interaction with a DVA (Krüger, 2018; Krüger et al., 2018). This study found that despite some confusion and uncertainty about interacting with a non-human counterpart, users tried to turn the system into a predictable, trusted partner, with whom they could potentially build a relationship. This finding was explained by the human need for security and belonging. Consequently, the use of the DVA to support health depends on the properties and intentions that the users attribute to the system – in both beneficial and unfavourable ways.

The idea of the 'Music Time-Out' is that with the help of the DVA, attentively listening to music will give patients sensory/aesthetic stimulation, distract them from the outside world, and allow them to focus on their own inner world. The focus is therefore still on the reception and processing of music. The programme is designed for Amazon's 'Alexa', an established DVA. The role envisaged for the DVA is on the one hand to provide music choices, and on the other hand to support the musical experience by directing the patient's attention and – this is the innovative step – asking open questions to stimulate narratives. Patients are invited to assess their own mental state, select music and, if necessary, deal with unsuitable choices, adopt a relaxed, non-judgemental attitude while listening to the music, identify the mental images that arise, capture and express them in spoken language, tolerate or regulate the associated emotions, and finally finish the process so as to be able to resume everyday activity.

The interaction with the DVA during the 'Music Time-Out' is modularised as follows: (1) the DVA welcomes the patient and directs their attention to their body and current mental state; (2) offers one piece of music from each of the above-mentioned categories, by playing a short segment of each and remembering the patient's choice; (3) leads a relaxation exercise; and (4) provides the selected piece, which is roughly 5 minutes in length. (5) When the music and a short silence have finished, (6) the patient is invited to focus their attention on the present and to resume their interaction with the DVA. (7) They are then given the opportunity to review and express verbally the feelings and images that have arisen, and (8) to answer open questions about the experience including its effect on their mental state. The idea is that the DVA is programmed to ask the next question once the patient has given an answer. To conclude, the DVA encourages the patient to record the experience retrospectively in an appropriate form (in writing, drawings etc.). (9) It then says goodbye after about 15 minutes in total (see figure 1; for technical information see Siegert et al., 2022).

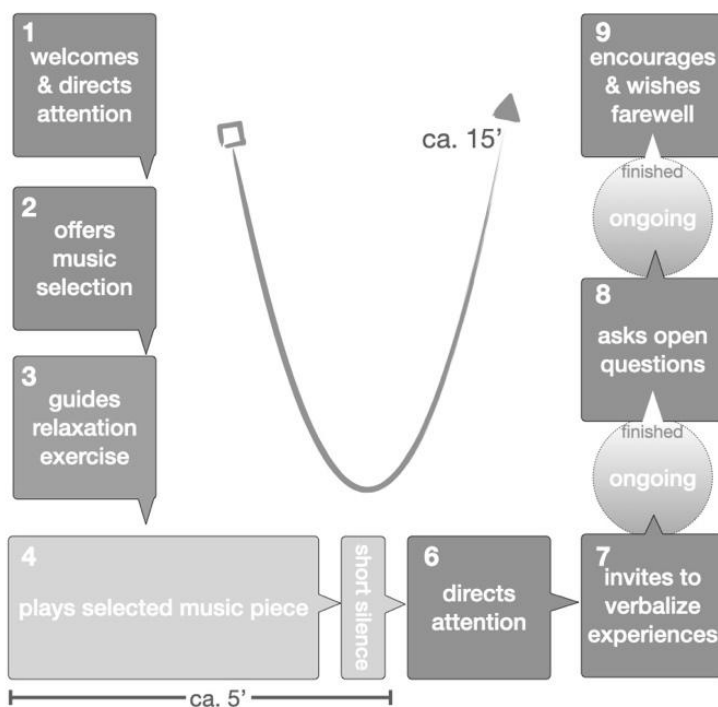


Figure 1: Digital voice assistant-modules for 'Music Time-Out'

Data handling

The programme does not store the patient's comments and/or choice of music in a back-end database. Nor does it use sensors to collect physiological data, or use speech recognition, voice recognition, or facial recognition to gather non-verbal data as indicators of intrapsychic processes. The programme also takes a different path to Ferguson et al. (2023), where the music selection is based on physiological measurements and not on personal decision by the user. Partly for ethical and psychological reasons, special emphasis is placed on the self-determination of the user, because any of these technological optimisations work imperceptibly and, in contrast to the interaction with a human (music therapist), cannot be questioned.

SUMMARY AND CONCLUSION

Current state of knowledge

The 'Music Time-Out' is not music therapy, but rather a therapeutically informed adjuvant intervention offered during aftercare to fill the gaps in outpatient treatment. It aims to promote autonomy in self-regulation and is based firstly on the everyday functions of listening to music, especially the positive effects of music and imagery, and secondly on the supportive function of an interactive virtual assistant.

The decision to use a psychodynamic approach is based on the characteristics of the target group, the goals of the 'Music Time-Out,' and the context of follow-up care after discharge from a multimodal treatment at a psychosomatic hospital. Due to its psychodynamic orientation, 'Music Time-out' differs from mindfulness-based approaches, such as an online music-based meditation programme presented recently by Kelly et al. (2025). However, adapting 'Music Time-Out' for use in different clinical contexts will require consideration of its psychological basis. This could potentially include the widely used mindfulness-based approach with consequences especially for therapeutic goals.

Unlike other socially interactive assistants designed for aftercare (e.g., Arora et al., 2024), which aim to simulate a therapy session with a human counterpart, the function of the DVA in the 'Music Time-Out' can be described as a (moderately) anthropomorphic interlocutor for the musical experience and for the intrapsychic processes that the music triggers. This decision reflects the concern that patients should not be misled into thinking that a DVA can experience music or empathise with highly subjective imagery. Rather than concentrating on the development of a highly effective technical simulation of human-like support, the design of the 'Music Time-Out' emphasises the relevance of autonomous self-care, which also informs the decision not to gather data and not to apply sensor technology.

When it comes to the use of music for aftercare, it must be assumed that everyday behaviour of psychosomatic patients may also be different compared to healthy individuals. As the 'Music Time-Out' is a structured adjuvant intervention, which would be introduced by a therapist, it can be assumed that unhealthy strategies for dealing with music in everyday life (Alluri et al., 2022) should not be encouraged. This is relevant because uncontrolled music listening for mood regulation by

adults who are overweight – one of the patient groups for psychosomatic treatment – showed unfavourable consequences for health (Ginström et al., 2025). This risk could potentially be reduced by engaging with the application of the 'Music Time-Out'. However, the risk of mind wandering (Nathan et al., 2023) or the occurrence of negative memories (Sakka & Saarikallio, 2020) should be kept in mind as, from a music psychology perspective, they cannot be completely ruled out, even if the time-limited nature of the 'Music Time-Out' provides a certain degree of protection.

Unanswered questions and proposals for the future

When scientifically evaluating a new intervention, the primary focus is not on its effectiveness but on how it is accepted and received by users. If the target group is a vulnerable clientele, initial assessments are obtained from healthy test subjects. In the case of this interdisciplinary project, two empirical sub-studies were conducted (Krüger et al., in preparation; Siegert et al., 2022), the results of which are not the subject of this article. It is crucial that at the present time, no statements can be made on the reception, user behaviour, and therapeutic effect of the 'Music Time-Out' for patients.

The authors believe that the first clinical application should only be considered if there are sufficient resources available for a thorough evaluation, including qualitative interviews with patients and therapists. It will be important to learn more about how the adjuvant use of the 'Music Time-Out' influences real-life therapeutic relationships. Patients, psychotherapists, and music therapists should explore and develop the use of 'Music Time-Out' together, to ascertain its acceptance, suitability for aftercare, and therapeutic effectiveness - also in contrast to the interaction with a human counterpart.

From the perspective of psychodynamic music therapy (Metzner, 2004, 2016) it will be interesting whether the 'Music Time-Out' acquires intrapsychic significance as a transitional object (Winnicott, 1971), and whether an intermediate space, as in psychotherapy (Ogden, 1985), is formed with the DVA. While this is theoretically conceivable, it depends entirely on how the user engages with the 'Music Time-Out'. Of particular interest here is how patients cope with the DVA's simulation of interest and intentionality (Fuchs, 2022). In other words, what types of relationships are formed and what role is played by mental imagery and the prereflexive physical and sensory affect produced by the music (e.g., Schmitz, 2011)?

Another area to be examined is the factors influencing sustained use and the efficacy of 'Music Time-Out', regardless of illness. These factors include musicality and music capacity, as defined by Chin et al. (2018) which includes the everyday use of music, educational level, and other socio-economic factors (Merzhvynska et al., 2024). Research is also needed on the suitability of music pieces or playlists for the 'Music Time-Out', particularly with regards to their musical properties. Lastly, the pros and cons of variety versus repetition of music, and of self-selection versus therapeutic prescription, should be weighed up in terms of their impact on the formation of mental imagery.

Final note

Due to gaps in provision, there is much to suggest that optimistic assessments of digital health services (Selke, 2023) and associated expectations will continue to grow. While technological developments such as emotional regulation strategy recognition by virtual assistants (e.g., Müller et al., 2024) are advancing, certain developmental steps in the healing process must still be completed independently by psychosomatic patients. The ‘Music Time-Out’ intervention addresses this issue.

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Ελληνική περίληψη | Greek abstract

Music Time-Out με ψηφιακό φωνητικό βοηθό: Σχεδιασμός μιας μουσικής παρέμβασης για τη συμπλήρωση της ψυχοθεραπευτικής/ψυχοσωματικής θεραπείας

Susanne Metzner | Ingo Siegert | Matthias Busch | Julia Krüger

ABSTRACT

Το παρόν άρθρο παρουσιάζει τον σχεδιασμό και την επεξηγηματική προσέγγιση μιας ψηφιακής μουσικής παρέμβασης με τον τίτλο «Music Time-Out», η οποία στοχεύει στη βελτίωση της ψυχοσωματικής μεταθεραπευτικής φροντίδας για ασθενείς με ψυχοσωματικές διαταραχές μετά από νοσηλεία. Μέσω της χρήσης ενός ψηφιακού φωνητικού βοηθού (Digital Voice Assistant – DVA), η παρέμβαση διευκολύνει την προσεκτική ακρόαση μουσικής, ενισχύοντας την αυτεπίγνωση και την συναισθηματική ρύθμιση. Θεωρητικά και ερευνητικά βασισμένη στην ψυχοθεραπεία, τη μουσική ψυχολογία και τη μουσικοθεραπεία, η παρέμβαση μέσω DVA καθοδηγεί τους ασθενείς σε διαδικασίες χαλάρωσης, φαντασιακής εξερεύνησης και συναισθηματικού αναστοχασμού. Τα πιθανά οφέλη σε σχέση με την αυτοφροντίδα εξετάζονται παράλληλα με τις τεχνολογικές προκλήσεις και τα ζητήματα διαχείρισης δεδομένων. Προτείνονται επιπλέον κλινική

εφαρμογή και αξιολόγηση, ώστε να εκτιμηθεί η θεραπευτική αποτελεσματικότητα και η εμπειρία των χρηστών.

KEYWORDS

μετα-θεραπευτική φροντίδα εξωτερικών ασθενών, μουσική παρέμβαση, ψηφιακός φωνητικός βοηθός, ψυχοσωματική διαταραχή, αυτοεπίγνωση, συναισθηματική ρύθμιση

TRANSLATED ARTICLE

Music therapy newly defined

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ABSTRACT

The definition of a therapeutic discipline provides an important demarcation and offers guidance for patients, interested parties, and professional actors in health care. The definition of music therapy serves to portray the therapeutic profession both to music therapists and to others within the public health care system. Thus, it contributes decisively to the profession's political profiling. A definition of music therapy must incorporate a wide range of approaches and methodologies. It must be valid for the fields of psychotherapy and remedial/special education, as well as more physiological forms of therapy such as neonatology and neuro-rehabilitation. In this article, different definitions are presented and critically questioned. This was carried out by using the grammatical and semantic units for defining music therapy that were introduced by Bruscia. Against the background of new developments within music therapy, the necessity for a new definition is shown. A new definition of music therapy is presented, and its conceptual components are explained.

KEYWORDS

definition,
music therapy,
intervention,
methods

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INTRODUCTION

According to its literal sense, a definition accomplishes two things: determination and delimitation. The first purpose of a definition is determination: it serves to enable a basic understanding of previously unknown things. Let's take the term squeegee as an example. The dictionary defines squeegee as a "rubber-edged implement on a handle for cleaning windows, etc." (Thompson, 1996, p. 886). With the help of this definition, one gets a pretty good idea of what a squeegee is. It is a tool for cleaning. However, our idea remains vague because, for example, nothing is said about the exact size, shape, or material.

The second purpose is delimitation. Through a definition, it indirectly expresses what something is not. Returning to our example, no one would think that a squeegee could be a musical instrument or that a squeegee lives in a zoo enclosure. The definition is so precise that it allows us to clearly distinguish the squeegee from a brush, a scraper, or a rag.

A good definition is therefore characterised by its ability to explain something in a generally understandable way and by its capacity to conceptually distinguish it from similar things. A definition should be short, precise, and understandable. However, brevity, precision, and comprehensibility are like squabbling siblings, each wanting a larger share of the cake, but only at the expense of the others.

Both aspects – determination and demarcation – are subject to conscious interpretation and unconscious projection. Our knowledge, our concepts, our ways of expression, our attitudes, and our attributions are shaped by the environment and socialisation. Therefore, no definition is perfect and everlasting. It reflects the current social, cultural, political and economic reality.

Why is a definition of music therapy needed? It should take effect and be understood where music therapy is practised and administered. This primarily concerns the health and social services sectors. The definition of music therapy is addressed to all actors within there, namely patients, relatives, treatment providers, entrepreneurs, administrators, and politicians. It follows that a definition is bound to the concrete health policy and social conditions. Furthermore, a definition contributes to the self-image within the professional group.

By defining music therapy, we want to say what our subject is, what our discipline is, what it does, and what it offers. We know how difficult defining music therapy can be within the music therapy scene in Germany. Therefore, the German Kassel Theses on music therapy (BAG-MT, 2021) say: music therapy is an overall term used to describe different music therapy conceptions. There are different methodologies and approaches in music therapy, and so a definition must take this diversity into account and also enable differentiation from other forms of therapy and non-therapeutic activities with music. Thus, defining music therapy is a balancing act between providing a clear and precise definition with proper boundaries on one hand, and encompassing the full complexity of the multifaceted professional practice of music therapists on the other.

Hardly anyone has dealt with the topic of defining music therapy as thoroughly as Kenneth Bruscia, who analysed and compared 100 different definitions (Bruscia, 2014). In doing so, he noticed that sentence components can be grouped into functional categories. Bruscia calls these categories grammatical and semantic units. We used the following formula to put these grammatical and semantic units together:

Music therapy is a/an [descriptors] [predicate noun] using [agents] with [recipient] and [therapist] in [setting] (to) [outcome].

The units are as follows:

1. Descriptors: Adjectives to describe in more detail
2. Predicate noun: determiner, defines the subject matter (music therapy), following one of three basic schemas:
 - Tool schema with terms such as use, application, or techniques
 - Process schema with terms such as process, approach, or form
 - Identity schema with terms such as discipline, profession, or theory
3. Agents: the means used, can be in context with strategies
4. Recipient: designation for patients or clients, possibly with reference to a need or problem (symptom)
5. Therapist: name and, if necessary, description
6. Setting: the environment or institutions in which music therapy takes place
7. Outcome: aims (activities), outcomes, and health domains

Bruscia's grammatical and semantic units are not always clearly delineated, but they do make it possible to compare different definitions of music therapy. Thus, we collected definitions from the music therapy associations in Germany, Austria, the United Kingdom, and the United States. We will now discuss these definitions, including Bruscia's definition. We aim to point out why they do not meet the requirements for a general definition of music therapy. Subsequently, we will present our own definition.

CRITICAL REVIEW OF SEVEN DEFINITIONS OF MUSIC THERAPY

Definition 1

A widely used definition in German-speaking countries comes from the German Music Therapy Society (Deutsche Musiktherapeutische Gesellschaft; DMtG). It reads: "Music therapy is the purposeful use of music within the therapeutic relationship to restore, maintain, and promote mental, physical, and spiritual health" (DMtG, 2021, under "Definition").

Central to this definition is the last word: health. For Bruscia, this would fall into the goals/outcomes category (Bruscia, 2014). Health, as used in medical disciplines, corresponds to the concept of salutogenesis (Antonovsky, 1997). In the same way, the World Health Organisation (WHO) does not speak of diseases but is oriented towards the maintenance and recovery of health, defining health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2021).

However, this is in contrast to the conceptual focus on disease as the starting point of medicine. The health care systems in western countries focus on concepts such as hospital, sickness benefit, and patient. There is much to be said for questioning the pathogenesis-oriented terminology of our health care system. However, if music therapy is to be defined convincingly for this system, it makes sense for pragmatic reasons to use the terms commonly used there. Likewise, we would argue for the

need to make use of this disease and deficit-oriented terminology when describing and defining music therapy.

Definition 2

Another definition comes from the German author Walther C. M. Simon (1975):

Music therapy is understood to be a diagnosis-specific treatment method of psychotherapy, which, oriented according to psychopathological requirements, uses the specific communication medium of music receptively and actively in order to achieve therapeutic effects in the treatment of neuroses, psychosomatic disorders, psychoses and neuro-psychiatric diseases. (p. 140)

This definition is presented here because it was the only one we found that met our requirements of medical vocabulary and a clear orientation to pathological issues. It was thus emphasised that the main capacities of music therapy are psychological means. The emphasis on psychotherapeutic qualities was certainly a milestone in the development and professionalisation of music therapy. Additionally, this emphasis also accounted for different psychotherapeutic orientations of the different music therapy schools.

This definition included psychotherapy because it was hoped that the music therapy profession would be included in psychotherapy legislation. However, this was ultimately not fulfilled in Germany. In the meantime, the clinical application of music therapy has developed further, promoted by the neurosciences, among other things. New methods and concepts such as cognitive therapy with music (Thaut & Hoemberg, 2014), music therapy for tinnitus (Cramer, 2018; Krick et al., 2017), or music therapy in neonatology (Haslbeck & Bassler, 2018; Umbrello et al., 2019) are now based on neurophysiological concepts. In this context, music becomes an agent that is able to directly influence bodily functions such as movement, respiration, or cognitive functions. Because of this, the term "psychotherapeutic" is too narrow. Interestingly, the term "psychotherapy" appears in none of the definitions analysed by Bruscia, neither as a propositional noun nor as a descriptor or strategy (Bruscia, 2014). Instead, many definitions convey a broader, quasi-bio-psycho-social understanding of music therapy. We will now consider other definitions in order to determine to what extent medical language and pathological orientation were applied.

Definition 3

The World Federation of Music Therapy (WFMT) places the optimisation of health, well-being, and quality of life at the centre of its definition and mentions a variety of application areas.

Music therapy is the professional use of music and its elements as an intervention in medical, educational, and everyday environments with individuals, groups, families, or communities who seek to optimize their quality of life and improve their physical, social, communicative, emotional, intellectual,

and spiritual health and wellbeing. Research, practice, education, and clinical training in music therapy are based on professional standards according to cultural, social, and political contexts. (WFMT, cited from Bruscia, 2014, p. 331).

An orientation towards clinical treatment reasons is not formulated here. The focus is rather on prevention, quality of life, and personal development ("spiritual health and wellbeing"). A clinical orientation is only implied by the use of the terms "medical" and "clinical training," which seems to be insufficient for characterising a therapeutic procedure.

Definition 4

The "clinical and evidence-based use of music" opens the definition of the American Music Therapy Association (AMTA). Music therapy is then classified as a health profession.

Music Therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program. Music therapy interventions can address a variety of healthcare and educational goals: promote wellness, manage stress, alleviate pain, express feelings, enhance memory, improve communication, [and] promote physical rehabilitation. (AMTA, 2021)

The AMTA definition places a much stronger medical emphasis by using terms such as intervention and healthcare. Yet, "educational goals" do not seem to fit quite right within the medical framework. Treatment goals are mentioned, which partly do not have a clear therapeutic outcome ("manage stress", "express feelings"). This is in contrast to the indication-guided procedure in medical treatment, which is based on experts (physician or therapist) initiating therapeutic measures. Like the WFMT definition, the AMTA definition consists of two sentences that do not overlap in content. It uses the tool schema ("clinical and evidence-based use") and refers to specific professional training.

Definition 5

Next, let's look at the British Association of Music Therapy's (BAMT) definition:

Music Therapy is an established psychological clinical intervention, delivered by HCPC (The Health and Care Professions Council)-registered music therapists to help people whose lives have been affected by injury, illness or disability through supporting their psychological, emotional, cognitive, physical, communicative and social needs. (BAMT, 2021)

In this definition, the pathological orientation is emphasised by the terms "clinical intervention", "illness", and "disability" as well as by the legal registration. The verbs "help" and "support" as well as the term "needs" seem to characterise an out-of-hospital application. Furthermore, the interventions

are narrowed down to psychological modes of action. The enumeration of target areas is conceptually overloaded, as seen in the linking of the words, “psychological”, “emotional”, and “communicative.” On the other hand, the expression “physical” should be explained in more detail.

Definition 6

Bruscia uses a process schema in his definition, in which music therapy is explained as a process:

Music therapy is a reflexive process wherein the therapist helps the client to optimize the client's health, using various facets of music experience and the relationships formed through them as the impetus for change. As defined here, music therapy is the professional practice component of the discipline, which informs and is informed by theory and research. (Bruscia 2014, p. 36)

Like the AMTA definition, Bruscia's definition also consists of two sentences. In contrast to the WFMT and AMTA definitions, a clear weighting is recognisable here. The first sentence contains the actual definition and could also stand on its own. The second provides a more precise definition of the subject's technical context without diluting the first sentence.

In the first sentence, the term *reflexive* stands out. What prompted Bruscia to insert this word? In the remarks, Bruscia explains that the term refers to (self-) observation, evaluation, and awareness in the process. By stating *optimise the client's health*, Bruscia aligns himself with the salutogenic approach. There are no statements about target areas, which at least does not support a classification as a therapeutic discipline.

Five of the six definitions discussed here share a common feature in that their formulations go beyond a purely medical application: "maintaining and promoting health" (DMTG), "improve health and wellbeing" (WFMT), "promote wellness" (AMTA), "help people" and "supporting ... needs" (BAMT), "optimize ... health" (Bruscia). Simon's (1975) definition is the exception here. In subject-specific terms, the main focus is on prevention and personal support. Prevention is characterised by the protection against illness and the promotion of health or health-stabilizing competencies (GKV, 2021). In Germany, preventive work is also part of the professional work of music therapists, even if this term is not usually used. Instead, the terminology used include "promotion" or "maintenance of health."

Definition 7

In the Austrian Music Therapy Act (MuthG), the practice of music therapy is defined rather broadly.

Music therapy is an independent, scientific-artistic-creative and expressive form of therapy. It involves the deliberate and planned treatment of people, especially those with emotionally, somatically, intellectually, or socially conditioned behavioral disorders and conditions of distress, through the use of musical means in a therapeutic relationship between one (or more) treated person(s) and one (or more) treating person(s) with the goal of

1. preventing, alleviating or eliminating symptoms or
2. to change behaviors and attitudes that require treatment or
3. promote and maintain or restore the development, maturation, and health of the person(s) receiving treatment." (Bundeskanzleramt der Republik Österreich-2021, translated by first author)

Although music therapy is initially referred to as the treatment of "behavioral disorders and conditions of suffering," terms such as "prevent," "promote," and "restore" are used to describe broader fields of activity (prevention, rehabilitation, support services) in which music therapists are also involved. This formulation accurately reflects the professional reality of music therapists but also obscures the characterisation of music therapy.

REQUIREMENTS FOR A DEFINITION

A definition should reflect the current state of development of music therapy. It should also include more recent developments beyond the focus on psychotherapeutic work. The therapeutic profile of music therapy should be clarified in the sense of a clearer positioning and characterisation of both the therapeutic and non-therapeutic offers of music therapists.

The definition should be formulated in a meaningful and generally valid way. It should be understandable and applicable not only for music therapists, but also for representatives of other health care professions, patients, administrators, and politicians. It should also be a basis for music therapy theory and practice. Music therapy can be defined either broadly, encompassing everything music therapists do, or narrowly, such as focussing on treating symptoms. The latter opens up the possibility to distinguish between music therapy methods that go beyond treating symptoms and to speak of *support services by music therapists*. In the following sections, we will present what speaks in favour of this narrower definition from our point of view.

APPROACH

The starting point for our work was Hans Strotzka's (1975) definition of psychotherapy:

Psychotherapy is a conscious and planned interactional process for influencing behavioral disturbances and states of suffering, which are considered by consensus (if possible between patient, therapist, and reference group) to be in need of treatment, by psychological means (through communication), usually verbal but also a verbal, toward a defined goal (symptom minimization and/or structural change of personality), worked out together if possible, by means of teachable techniques based on a theory of normal and pathological behavior. Usually, this requires a viable emotional bond. (p. 4)

What was decisive for us was this definition's coherent linkage of its key components. Additionally, it uses clinical terms by starting from a substantial health problem (symptom) over pre-defined goals to strategic interventions. Because of this, we found that this definition effectively

embodies what we consider essential for integrating a therapeutic discipline into the healthcare system. Moreover, unlike Simon's (1975) definition, the element of the therapeutic relationship is added. According to Bruscia, this is based on a process schema (interactional process). The actors (patient, therapist), the agents (psychological means, mostly verbal), the goals (symptom minimization and/or personality change) and the strategies (techniques based on a theory) are listed and linked in a comprehensible way. The definition unfolds and explains itself as a closed chain in which each link matters. If one is missing, the chain is not functional.

Based on Strotzka's definition and taking into account the presented developments of music therapy, we have embarked on a new music therapy definition. This was discussed and elaborated in a dialogue between the authors – mostly by video call and once in person. A cloud text file served as a working platform. Proposals were collected, discussed, and updated and/or discarded several times over a period of more than 14 months.

This collaboration was fuelled by our different professional backgrounds. The first author works as a clinical music therapist specialising in treating patients with neurological conditions and brings experience as a research-based rehabilitation scientist. The second author is a music therapist, supervisor, and professor emeritus with teaching and research interests in music therapy theory, improvisation, and ethics.

THE NEW DEFINITION

The new definition is as follows:

Music therapy is a scientifically based therapeutic discipline in which music interventions are applied to alleviate psychological, somatic, psychosomatic, and cognitive symptoms in a collaborative activity between therapist and patient.

The chosen terms are successively explained.

“scientifically based”

Strotzka states that psychotherapy is “teachable” and takes place on “the basis of a theory of [...] behavior.” Our formula “scientifically based” is meant to express both. Scientificity is based on traditional empirical knowledge and clinical studies, and implies that principles of action, forms of application, and interventions can be derived and described in a comprehensible way. This is associated with teachability. The theory of music therapy includes findings from various scientific fields such as psychology, music psychology, musicology, medicine, rehabilitation science and so on. Due to its scientific orientation, this theory is committed to permanent questioning and updating – for example, based on research results.

“therapeutic discipline”

Music therapy is a therapeutic discipline that includes different methods with specific techniques. The term “discipline” implies a comprehensive, independent theory that relates to different areas of

application from which indications and treatment goals can be derived. Through its characterisation as therapy, music therapy is focused on the treatment of pathological phenomena (symptoms). Even though prevention is rightly considered an important field of work for music therapists, it is to be distinguished from therapy. The term “prevention” can be used when a disorder in need of treatment, classified according to ICD-10 for example, has not yet occurred. Therapy is indicated when corresponding symptoms have already been diagnosed. While other authors have added prevention to the definition of music therapy as demonstrated above, we decided not to do this. Music therapy thus regains its genuinely therapeutic quality. Furthermore, the term “therapeutic discipline” implies a profession and an associated professional qualification. Accordingly, a direct reference to the profession of music therapist has been omitted in this definition.

“collaborative activity”

Music therapy is characterised by the relationship between therapist and patient. Both therapist and patient are active in music therapy and act in a collaborative alliance. This collaboration is directed towards a goal that has been mutually agreed on. Usually, the patient has the role or responsibility of introducing a goal into the therapeutic process. This goal-setting from the patient is supported and guided by the therapist. Setting the goal is an ongoing process throughout therapy. It is up to the therapist to set realistic and achievable goals and to suggest, offer, and/or choose feasible music interventions accordingly. Thus, the whole process is driven by a reciprocal interactivity between therapist and patient. We characterise this as collaborative activity.

This is true even if the goal cannot be negotiated verbally and linguistically, for example, due to limited mental capacity. Strotzka's “interactional process” thus acquires a collaborative quality. The clause on the therapeutic relationship that follows there is omitted here. As an effective factor, the relationship between therapist and patient is an essential element of therapy, especially of psychotherapy. However, it is not specific for the definition and delimitation of music therapy. Therefore, it was not used to characterise music therapy.

The formulation chosen instead relativises the competence and influences the gap that is often associated with the terms “therapist/doctor” and “patient,” especially in a clinical context. In addition, the emphasis on joint action (in the music interventions) creates a distinction from music medicine.

“patient”

The term “patient” for the recipients of music therapy was chosen to be consistent with common medical terminology. In addition, it supports the premise that music therapy is always directed at phenomena (symptoms) in need of treatment and it conforms to conventions and practical realities in medical settings.

In contrast, in non-clinical settings such as special schools, communal facilities, residential facilities for elderly, or for people with special needs, music schools, etc., other terms such as “resident,” “client,” and “student” are primarily used. This has its justification and offers – with regard to the institutional context – advantages for the method used in music-therapy work and the working alliance. From our point of view, it does not contradict the new definition.

“music interventions”

An intervention “is an action (e.g., training, treatment) whose effect on a target characteristic is studied” (Wirtz, 2020, p. 873). *Music intervention* is used to highlight that agent by which music therapy differs from other forms of therapeutic intervention. Music is not determined in this definition. The term thus encompasses different conceptualisations of music as a medium of music therapy – for example, as a stimulus for certain effects, as a medium for meaningful interactions and experiences, as a form of expression, as a relational event, or as a symbol (Weymann, 2020).

In this context, music interventions are to be understood as reflexive in Bruscia’s sense (Bruscia, 2014). On one hand, this includes the possibility for verbal reflections. On the other, this characterises a process that moves in the interplay between the actors. The concrete handling of music (methods, techniques) takes place in the sense of the respective objectives. Thus, one can also speak of music intervention when the musical interaction is not described as a planned or targeted “use” of music, but as an “emerging” phenomenon of an almost dreamlike communication between people. The possibility of this emergence is methodically and technically provided, its meaning theoretically framed, and therefore also “strategically” determined. A more differentiated presentation of the various music therapy strategies and principles of action (cf. Schwabe & Reinhardt, 2006) was not undertaken. The naming of the symptom areas seemed more meaningful to us.

“alleviate symptoms”

The use of the term “symptom” results from its characterisation as a medical or psychological therapy. In medicine, the symptom represents the starting point of a treatment. Seen as an indication, the symptom also points to a concrete and appropriate therapy.

Strotzka has expressed this with regard to psychotherapy by the terms “influencing behavioral disorders and states of suffering” and “in the direction of a defined [...] goal”. Our formulation aims to address these aspects in an understandable way. The “alleviation of symptoms” closes the logical gap between the goal (of the therapist and the patient) and the music interventions that are chosen. Even though medical care is often used to “remove” symptoms, we thought it more feasible to use “alleviate” instead. The enumeration that then follows is intended to represent all fields of application of music therapy.

CONCLUDING REMARKS

The new definition aims to be meaningful to health care professionals, patients, relatives, and stakeholders. The process of music therapy and the character of music interventions are viewed as an entity that may be directed to psychological or somatic symptoms. Therefore, the new definition refers to the bio-psycho-social understanding of illness and therapy, according to which every sign of illness and every therapeutic intervention has a physical, psychological, and communicative-social manifestation (Uexkuell, 1991).

By naming the indication fields of somatics and cognition, the scope of action is extended beyond the psychotherapeutic context into the field of physical functions. This ties in with the understanding of the international, especially the Anglo-Saxon, music therapy scene and the

increasing spread of functional-physiological approaches. By referring to somatic and cognitive disorders, such important fields of work such as geriatrics, neurology, and developmental disorders are integrated.

The conceptual restriction to symptoms requiring treatment, i.e., to a medical necessity as the basis of therapy, seems to make sense to us with regard to the process of professionalisation and quality assurance of music therapy. We would like to emphasise that music therapy is, of course, more than just a means of alleviating symptoms. Nonetheless, the symptoms in our definition serve as the links between setting goals and creating the music intervention. This relates to the practical working conditions in health care.

With the clear identification of music therapy as therapy, the professional core area of competence of music therapists is emphasised, from which we can convincingly present our actions, our professional (meta-)communication, and our embedding in the most diverse institutional contexts of the health care system. For example, to effectively advance the integration of music therapy into treatment guidelines (BAG-KT, 2021) and further the path toward professional recognition, alignment with the medical understanding of illness and therapy is essential.

Numerous uses of music in health care can be helpful or even healing without falling under any definition of music therapy, even if they are performed by music therapists. Foster et al. (2016) list ten different domains under the umbrella term Music Care, of which music therapy is one. The other domains include, for example, Music Medicine (Spintge, 2018) or the care of the "Sound Environment" of the clinic or Musical Soundscape Intervention (Weymann, 2021). Concert events, singing events in the hospital, etc., can be effective for quality of life, community care, entertainment, or culture and can serve to maintain health. Community music therapy can also be seen in this context. Here the emphasis is not on addressing problems that require therapeutic treatment but on the "interactional relationships between individuals and the communities within which they live" (Steele, 2016, under "Key Qualities of Community Music Therapy").

The music interventions in the areas above are not carried out because of specific indications. The new definition is intended to sharpen internal understanding and external presentation by not referring to them as music therapy. In spite of this, these activities can be carried out by music therapists.

In this way, we want to make a contribution to improving the understanding between music therapists and co-therapists, patients, their relatives and other persons in the health care system. By clearly and comprehensibly locating music therapy in the health care system, we also want to promote better implementation and recognition by those who finance music therapy. Additionally, this is intended to encourage the music therapy community to reconsider and refine the therapeutic profile of music therapy.

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Ελληνική περίληψη | Greek abstract

Η μουσικοθεραπεία προσδιορισμένη εκ νέου

Stefan Mainka | Eckhard Weymann

ΠΕΡΙΛΗΨΗ

Ο ορισμός μιας θεραπευτικής ειδικότητας παρέχει μια σημαντική οριοθέτηση και προσφέρει προσανατολισμό για τους ασθενείς, τους εμπλεκόμενους φορείς και τους επαγγελματίες στον τομέα της υγειονομικής περίθαλψης. Ο ορισμός της μουσικοθεραπείας εξυπηρετεί την παρουσίαση του θεραπευτικού επαγγέλματος τόσο στους μουσικοθεραπευτές όσο και σε άλλους επαγγελματίες του δημόσιου συστήματος υγείας. Ως εκ τούτου, συμβάλλει αποφασιστικά στον επαγγελματικό πολιτικό προσδιορισμό. Ο ορισμός της μουσικοθεραπείας πρέπει να περιλαμβάνει ένα ευρύ φάσμα προσεγγίσεων και μεθόδων. Πρέπει να είναι έγκυρος για τους τομείς της ψυχοθεραπείας και της θεραπευτικής/ειδικής αγωγής, καθώς και για πιο σωματικές μορφές θεραπείας, όπως η νεογνολογία και η νευροαποκατάσταση. Σε αυτό το άρθρο, παρουσιάζονται διαφορετικοί ορισμοί και υποβάλλονται σε κριτική ανάλυση. Αυτή η διαδικασία

πραγματοποιήθηκε χρησιμοποιώντας τις γραμματικές και σημασιολογικές μονάδες για τον ορισμό της μουσικοθεραπείας που εισήγαγε ο Bruscia. Με φόντο τις νέες εξελίξεις στο χώρο της μουσικοθεραπείας, αναδεικνύεται η ανάγκη για έναν νέο ορισμό. Παρουσιάζεται ένας νέος ορισμός της μουσικοθεραπείας και εξηγούνται τα εννοιολογικά του στοιχεία.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

ορισμός, μουσικοθεραπεία, παρέμβαση, μέθοδοι

INTERVIEW

Reflecting on the growth of music therapy across a lifetime: Past, present and future insights

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ABSTRACT

The development of music therapy as a profession varies significantly across global contexts, shaped by local education, clinical practice, and research initiatives. Understanding these national and international trajectories is critical to informing the profession's ongoing evolution. This interview contributes to that understanding by exploring the career and perspectives of Alison Short, a leading Australian music therapy clinician, researcher, and educator. The timing of this interview is particularly significant, aligning with the 50th anniversary of the Australian Music Therapy Association (AMTA) in 2025, a milestone that invites reflection on the profession's growth and future directions in Australia. The semi-structured interview process of the paper captures Short's written responses to a series of questions focusing on her diverse professional experiences. These responses were further explored through virtual meetings, enabling deeper discussion and critical reflection. The resulting narrative highlights key themes that have shaped Short's contributions to music therapy, relating to clinical practice, academia, research, the evolution of music therapy education in Australia, and the broader professional challenges and achievements witnessed over several decades. By exploring and documenting Short's reflections, this interview offers valuable insights into the development of music therapy in Australia and the interrelationship between individual career trajectories and broader professional growth. These insights are not only relevant for understanding the Australian context but also contribute to global conversations about sustaining and advancing music therapy as a dynamic, evidence-informed, and person-centred profession.

KEYWORDS

development of music therapy,
Australian Music Therapy Association,
interview

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Alison Short is Associate Professor, Music Therapy/Music & Health at Western Sydney University, Australia. She is a foundational member of music therapy in Australia as an initial trainee and registered music therapist of 43 years, also holding board certification for 34 years. Alison has clinical experience in aged and palliative care, mental health, medical and community settings. Her broad scope of education, supervision and research in music therapy-related fields is internationally recognised and valued, evidenced through publications, invitations, and collaborations. [A.Short@westernsydney.edu.au] **Annie Heiderscheit** is Professor of Music Therapy and Director of the Cambridge Institute for Music Therapy Research at Anglia Ruskin University in Cambridge, United Kingdom. She has been a board-certified music therapist for over 30 years and, a marriage and family therapist 15 years, working in mental health, medical and community-based setting. She has over 20 years of experience conducting research and teaching undergraduate and graduate courses and supervising at the doctoral level. [Annie.Heiderscheit@aru.ac.uk]

Note: The development of music therapy as a profession is unique in countries around the world and influenced by the professionals engaged in education, practice, and research (Ucaner & Heiderscheit, 2016). Understanding the history of the profession nationally and globally is important to ensure that we learn from our individual and collective experiences to use this to support our future growth and development. The purpose of this interview is to hear and learn from the experiences of an experienced music therapy clinician¹, researcher and educator in Australia. This is timely as the Australian Music Therapy Association (AMTA, 2025) embarks on celebrating their 50th anniversary in 2025. This interview is structured around an interview with Alison Short, Associate Professor at Western Sydney University. The interview included questions intended to explicate Short's experiences across her career as a music therapy clinician, researcher and educator. These questions were provided to Short by Annie Heiderscheit to be able to respond in writing, including with relevant references, and then reviewed and discussed through a series of virtual meetings. What is included throughout the paper are Short's experiences, including reflections and insights emerging from them.

Annie Heiderscheit: As you reflect on your career, is there a moment that stands out to you and what did you learn as a result?

Alison Short: Well, talking about music therapy – it is not an easy gig as a professional, not only the work we do but also the way people see us as we engage in our everyday music therapy practice, relating to clients and consumers as we create and support their music, engagement and therapeutic process! I remember a situation in an aged care facility, where I had been practising as a music therapist for over 20 years, highly trained and experienced as an accredited music therapist in both Australia (RMT) and the United States (MT-BC). I was facilitating a group music therapy session in an open lounge room, where I was adapting and tailoring the music I was playing on the keyboard, to sensitively attune to the needs of people in the group, and it was all going very well. Into the room comes a nursing assistant, who was quite familiar with the facility, aged care and its workings – she was bringing in another resident part-way through the music therapy session. As she left, she turned to me, patted me on the shoulder, and gestured to and commented on my music playing, saying quite loudly, “don't worry, dear, one day you'll be a professional!!!” Hmm, I thought. A professional, you say? I was lost for words...

Both individually and professionally, we often struggle to get the message out about who we are, what we do, our specialised training and although this has improved since I became a credentialed professional, there are still many challenges. So the ongoing learning, for all of us, is about understanding and communicating who we are and what we do as music therapists. As one of the most senior pioneers of music therapy in Australia, I ask the question: How can we gather together all of who we are, what we are, and where we are going, as a music therapy profession in Australia – as we seek to push forward even further into creativity and diversity as foundational to our profession? As challenging as this may be it is vital to our growth and development as a profession. Reflecting on our journey and our experiences is key.

Annie: Across the arc of your career, you have engaged as a clinician, educator and researcher. How has each role influenced or informed the other? Are there pivotal or significant moments that stand out to you in these areas?

¹ The term clinician refers to an individual who uses a recognized scientific knowledge base and has the authority to direct the delivery of personal health services to patients (Donaldson et al., 1994, p.16).

Alison: Great question, and let us focus on each of those separately first! At the beginning of my career, I happened into the first course of music therapy in Australia, not really knowing what it was, after being encouraged (nagged) by my conservatorium teacher, Miss May Clifford. I had been having piano lessons with her from since before I was a teenager and under her guidance, I successfully completed an advanced performance diploma at the age of 17 (Associate in Music, Australia: Australian Music Examinations Board). May Clifford had seen music therapy in action in the UK on her many trips to visit family there, and as a part of the University of Melbourne Conservatorium of Music she knew that the first music therapy program was about to commence. Not only that, she knew me well from over six years of teaching, and felt that I would be ideal for this course of study. Well, after being very ill with glandular fever/mononucleosis in my final year of secondary school, this was the choice I was given. So, I accepted with the intention of exploring this thing, this “music therapy,” knowing that other options were also possible. Little information was available at first, and the Australian Music Therapy Association (AMTA) was in its infancy (Short, Grocke & Fuller, 2022). In time, under the guidance of Denise Grocke, we developed our knowledge and skills. With my student colleagues, we gave the first Australian university-trained music therapy student conference presentations (Kuehne & Cosgriff, 1980) and we were exhorted to be pioneers of the profession. I took up this task in various ways including my first solo conference presentation (Short, 1983), my first peer-reviewed journal publications (Short 1990, 1991), including a publication in the inaugural *Australian Journal of Music Therapy* (Short, 1990). I was always interested in exploring and extending applied music therapy practice (Short, 2018a), and in the days before a strong focus on research I already undertook reflective practice to push the boundaries of music therapy understandings and practice. I connected knowledge from other areas with my then current experiences to inform more about working with an angry patient (Short, 1983). I reflected and reviewed data about programs and applications in a range of contexts. As Senior Music Therapist, I initiated a major review of the Red Cross Music Therapy Service and its outreach programs (Boots et al., 1985). While working for Red Cross, I ran the first palliative care music therapy sessions at Bethlehem Hospital, later developed by Clare O’Callaghan, and I ran the very first music therapy sessions at Royal Melbourne Hospital starting 1984, subsequently developed by Emma O’Brien. I also systematically reviewed standard reporting within an aged care music therapy program (Short & McIntosh, 2003) and gathered evidence about an innovative approach combining movement, relaxation and imagery to address clinical needs in aged care (Short, 2007).

Many of my experiences as a music therapy trainee shaped my subsequent applied clinical practice. On placement at Wimmera Base Hospital (Horsham, Victoria, 1981) I remember attending a presentation about client/patient perspectives. They quoted a participant dismissively saying: “Here I sit at a great big loom/ Doing God knows what for God knows whom?” which highlighted the need for meaning and purpose. This profoundly influenced me in the way that I was working with older people at the time – why use a shaker or a drum? How could I help people connect to music activities as being adult and meaningful, and how could they feel empowered in their engagement? This subsequently formed a major theme within my music therapy practice.

My second music therapy training at New York University (1985-1987) brought even more challenges and learning about applying music therapy, at a time when there was not yet any type of Masters level music therapy training in Australia. This well-established training led by Barbara Hesser, and supervised by Peter Jampel, developed and extended my practice in many ways, including a better

sense of being “in the moment” emotionally and using my music skills in both advanced improvisation and advanced counselling classes, alongside student colleagues such as Michelle Forinash, Alan Turry, Louise Montello, Josee Prefontaine, Tina Brescia, Jenny Martin, Christine Routhier, David Marcus, and others. As a result of my NYU training, I moved away from an activities-based focus into a deeper understanding of musical therapeutic group process, seeking to reflectively understand and explicate what I was seeing, hearing and doing (Short, 1992b; Short, 1995).

Although Denise Grocke had introduced the idea of Guided Imagery and Music (Helen Bonny) at the University of Melbourne, it was only at New York University that I became the first Australian music therapist to train in Guided Imagery and Music (under Madeleine Ventre), later completing my training to become a Fellow of the Association for Music and Imagery (1989) and becoming the first accredited GIM Primary Trainer in the Southern Hemisphere (1994), just in time for the inaugural Graduate Diploma in Guided Imagery and Music (GIM) at the University of Melbourne (commenced 1995) and aligned with being a foundational member of the Music and Imagery Association of Australia (1994). Practising GIM fitted me like a glove combining my deep understandings of Western classical music with psychotherapy and intriguing understandings of meaning, purpose, and empowerment for clients (for example, Short, 2023b). I found ways to integrate music and imagery into my everyday work in aged care (Short 1992a, 1992c) and my private practice, deriving theoretical knowledge from everyday experiences as I sought to understand more (Short, 1990, 2019a); I continued to work to know more about the practical, interactive, engaged nature of music therapy practice, including using practice aspects, for example voice tone, to inform subsequent research projects (Short, Cheung, et al., 2022).

From the beginning of my music therapy training and through all of my practice, based on my extended interests and experiences, I have had an interest in the applied hospital context, which was evident in my choice of doctoral thesis topic (Short, 2003) and further work in acute care (Short, 2019a; Short & Ahern, 2009; Short, Ahern, et al., 2010; Short & Palaniappan, 2025) and current projects around music to assist with mental health and wellbeing related to fertility treatment (Short, Andreadis, et al., 2025; Short, Cheung & Andreadis, 2025).

Annie: What led to your interest in research?

Alison: Research is the foundation of our evidence-based practice. Research gets us where we need to go, as a profession, and both of our music therapy courses in Australia have a strong research base. Australia is known around the world, for its a high rate of music therapists with doctoral degrees and for its excellent research and research collaborations. Research is so essential for our profession! And it is something that I have committed much of my effort and energy towards – both within and outside of music therapy, in my various roles (Short et al., 2010; Short, Ní Chróinín, et al., 2025). In fact, research flavours much of my thinking, and more research is needed for an informed future in many aspects of music therapy practice. Across both my health services and music therapy research employment and experiences, I have engaged in many types of research, including: Document review, process evaluation, consumer survey, validated data collection instruments, feasibility study, clinical trials, mixed methods, qualitative/narrative/semiotic study, acoustic analysis, practice-based research, cultural research, arts-based research, and more.

Back in 2014, before I started at Western Sydney University, an external audit said that more needed to be done about teaching research and developing the research community. Since 2014, aside from my many other tasks, I have sought to use my previous ten years of experience as a research-only academic to foster, build and support an emergent research culture here in Sydney. It has been tough work! But the number of students and alumni presenters at the 2024 AMTA conference, the number and range of awards that have been received, the number of research student graduations and the sheer output of papers and presentations in the national and international sectors shows that outputs have changed. For example, in the last five years, I have 35 peer-reviewed publications and eight research student graduations, with many significant invitations to lecture and present, such as a paid invitation to the Hamburg University Music Therapy Public lecture series on Music and Environment in Hospitals (Short, 2018a), an invited plenary presentation at a medical thoracic and pulmonary conference in March (Short, 2024a), the Korean Association for Music and Imagery 21st Anniversary Lecture (Short, 2024b), explaining about music therapy research in the inaugural Mexican Music Therapy training (Short, 2022a) and presenting/consulting on a new music therapy course for the World Federation of Chinese Medicine Societies in Guangzhou, China (Short, 2025c).

Not only that, but here in Sydney we have built many collaborative projects with community and industry, in line with the World Health Organisation's Sustainable Development Goals and the values of Western Sydney University, to make a difference to people who are marginalised or forgotten in our society. This has included representations to the Ministry of Health (Short, 2023a) in connection with my ongoing commitment to the South West Sydney Health Arts Partnership since 2016 (SWSLHD, 2024), fostering research capability. One interesting research project has been about change management and uptake of the arts into hospitals following the NSW Ministry of Health strategy, amongst many other projects (MacRitchie, Short, Dion, & Chow, 2022; Stone & Short, 2023; Vadali, Ní Chróinín & Short, 2024).

Annie: What changes have you witnessed in music therapy education and training in Australia across your career?

Alison: Music therapy education has blossomed in Australia since the first six graduates at the University of Melbourne in 1982. I was lucky enough to be one of that first class, and little did we know where we would all end up! Not only are our Australian music therapists highly regarded around the world, but we have collectively as Australians held substantial educational roles in many places. This includes Ireland, Norway, the UK, USA – and the list goes on with many guest lectures all around the world. I personally have experienced the challenges of initiating or re-designing music therapy educational programs, including as an inaugural music therapy lecturer at the University of Technology, Sydney (1994) and as the first approved primary trainer in GIM in the Southern Hemisphere (1994). Extending my knowledge as a university educator, I undertook the full *Graduate Certificate in University Learning and Teaching* at the University of New South Wales (2012), which set me up for my current educational role at Western Sydney University. In the last eleven years during my employment at Western Sydney University, our Master of Creative Music Therapy (MCMT) has gone from 17 students to 73 students total, all the while adapting our teaching to improve and excel in the way that we foster the individual growth and development of each individual student, even during

the pandemic (Garrido et al., 2024). I have enjoyed mentoring and working with others in the music therapy teaching team at Western Sydney University, and the new curriculum approaches that emerged especially as I handed over leadership of the program to my close colleague Dr Al Fuller. We have a saying at Western, which we typically repeat to the whole student class at least once every semester, and often more times. It goes something like this: “You are here in this course because we saw something in you that said to us that you would make a great music therapist. You still need to do the work, but you will get there, and hold onto that!” Our music therapy course is inclusive of various learning needs, including people living with dyslexia, medical issues, sensory and neurodivergent strengths and challenges. Whilst we are clear about the difference between our roles across the therapy/education divide, our therapeutic sensitivity and creativity guides the way that we educate others (Lokhee, 2023; Lokhee & Short, 2025; Short, 2022b).

In addition, my educational role with my research degree students has resulted in a wide range of successful publications (Bortolazzo et al., 2025a, 2025b; Dilati et al, 2025; Fuller et al., 2022; Fuller & Short, 2020; Jeffrey & Short, 2025; Jeffrey et al., 2025; Stone & Short, 2023; Stone et al., 2025; Whalan & Short, 2023). Beyond Western Sydney University, I am joint Chief Investigator on a large international project to review, and in due course improve, music therapy educational practices across the world, with multiple current and pending publications (Heiderscheit & Short, 2024; Murphy et al., 2025; Short & Heiderscheit, 2023, 2025).

Annie: How have music therapists come together to support the music therapy profession in Australia?

Alison: So now let’s talk about collective governance in music therapy. From the beginning, AMTA was founded with a solid Constitution and well-developed governance procedures, and for that we have Denise Grocke and Ruth Bright to thank, as founding members of the AMTA (Short, Grocke & Fuller, 2022). Since it began in 1975, AMTA had a strong sense of ethics and standards of practice, and well stated professional competencies guiding training and practice, which have all been reviewed, updated and amended over time. Leadership and governance by AMTA have been shown with regular conference, professional development and workshop activities. Tracking the development of AMTA and its members had been well captured in Conference Proceedings, Newsletters and the *Australian Journal of Music Therapy*. Australia has also made significant contributions to the establishment and subsequent running of the World Federation of Music Therapy (1985), providing two past Presidents: Ruth Bright and Denise Grocke. The geography of Australia as an enormous continent presents considerable challenges to any national organisation. One of the ongoing challenges for AMTA has been to demonstrate representativeness of the whole of Australia. Over time, there have been three Presidents in other states: Ruth Bright in Sydney, Vicky Abad in Brisbane (2018-2020) and myself in Sydney (1996-1999), beyond the many Presidents based in Victoria, and all presidents have sought to help everyone in Australia feel included in the AMTA of the present and future. The strong sense of ethics, standards of practice and professional competencies in music therapy in Australia has united us and served us well, engendering respect and accreditation from other professions (such as APHRA, 2025), as well as ensuring that our high standards for practice and research continue, all of which can be found on the AMTA website (AMTA, 2025).

Annie: What has helped deepen and sustain your engagement in music therapy over time?

Alison: Fundamentally a creative approach to life and work has been my inspiration. Early on, I was intrigued by the notion of creativity, and to be honest as a high-level classical pianist I was not sure how creative I really was. Yes, I could reproduce the Schumann Piano Concerto and play it in a public performance with orchestra to graduate, to critical acclaim, but was this really creativity? So I set out to investigate further. One of my early conference presentations was based on my explorations around creativity and developed my understandings that there were many types of creativity (Amabile, 1983; Short, 1984). I began to understand that creativity was not only about something completely novel and “out there”, never been done before, but creativity was also about taking things already evident and linking them in a new way, finding new connections, new synergies, new integration. Aha! So yes, this was definitely how I was practising my creativity. Trying new ideas from diverse contexts, linking them together, seeing how this made things better, made a difference. This is evidenced in the many models, frameworks and approaches that I have explored and created across my music therapy and research career (Short, 1990, 2019a; Short et al., 2015; Short & Ahern, 2009). Undertaking a Character Strengths Profile after successfully being selected for the prestigious Franklin Women health researcher mentorship program (Franklin Women, 2025; VIA Institute on Character, 2025), my top three strength attributes came up as *Kindness, Spirituality* and *Creativity* – and this has been helpful in refining my leadership skills, especially in terms of mentoring, engagement and creative problem solving around teaching and research proposal development with local and international projects and with collaborators across a wide range of contexts.

In fact, music therapists by nature have a creative approach to everything! We can be rightly pleased with how we have pooled our creativity to develop many aspects in the AMTA – and how can Al Fuller and I ever forget the first AMTA website which we created and then demonstrated at the conference in Melbourne in 1999. Such a long time ago, and how things have grown and developed since! Look at our lovely logos and graphics from the 49th AMTA National Conference (<https://www.austmta.org.au/events/2024-conference>), and a big thank you to Lauren Bortolazzo and all the others who have contributed their creativity to AMTA. And then there has been a great deal of music at all our conferences; music and creativity are foundational to what we do!

Creativity also supports research, surprisingly more than you might think, and right from the beginning I was a creative collaborator, for example starting my PhD with the University of Technology, Sydney, in the School of Nursing, Midwifery and Health in 1996. I have undertaken GIM and cardiac rehabilitation projects (Short, 2021a; Short et al., 2013; Short et al., 2011) and have extended into related areas (Short, 2025b; Short & Palaniappan, 2025). Despite additional projects by Karen Schou (2008) and Blichfeldt-Ærø and colleagues (2022), similar work using GIM in cardiac care has yet to be published. Many of my coursework and research students presented at the 2024 Conference or published about the creative ways they have been approaching problems and seeking answers for practice and knowledge development in recent years (such as Fuller et al., 2022; Lehmann-Kuit et al., 2023; Whalan & Short, 2023).

Annie: How has creativity helped address recent challenges?

Alison: We were challenged throughout the COVID-19 pandemic (Heiderscheit & Short, 2024), and creativity is indeed what helped us get through it all! The effects of the pandemic called on us to adapt our music therapy practices by using our creativity and creative problem solving. At Western Sydney University, we had already been adapting to the digital age, and now into the future we are also adapting to the use of artificial intelligence in our practices. We exercise our inner creativity in the way that we use our critical thinking to address the needs of a client, in the way we write a song, create an improvisation, or use our words to respond to a client in distress; and the ways we create programs, publications and engagement materials to talk about our profession.

Annie: What have you learned in navigating professional challenges?

Alison: One of the most wonderful things I observed during the pandemic, and that I see every day in our students, alumni, and other music therapists, is the capacity of people to connect with and support each other, often in quite dire circumstances. Even recently, when one of our students had had a close bereavement, I saw student colleagues lingering, chatting, supporting, making them smile, rather than go and take the learning break they were entitled to. We gain by being together, all of us, by sharing and connecting. It is the way we work as professionals, and who we are as people, both individually and collectively as AMTA.

My own connectivity stems from both my wide range of roles as a health services researcher and also creatively making the most of opportunities wherever I could find them – both linked to nursing and allied health, and to research institutes such as the MARCS Institute for Brain, Behaviour and Development and the Translational Health Research Institute (THRI) at Western Sydney University. Finding like-minded music researchers with additional technical skills at MARCS, I was delighted to work with Andrew Milne and others to investigate the voice and GIM in the clinical context, with both a funded research project and subsequent Psychology Honours projects (Latecka, 2022; Kass, 2022; Short, Cheung, et al., 2022). These projects form another body of music therapy research which has not yet been extended but this holds great promise for the future, including with international collaborators.

Connectivity occurs not only within our own and related disciplines, but also within the way that we connect with others in teams in our practices. Sometimes we are not as well understood as we would like to be, as I noted at the beginning of our interview. For this reason, at WSU we have developed the *Music Health and Wellbeing Continuum* as a graphic for discussion to outline the different roles influencing practice and research (Short et al., 2019; Short & MacRitchie, 2023). This Continuum was developed as part of an interprofessional process within Western Sydney University and then tested with national and international key informant feedback based on carefully designed questions and applicability, in a Delphi-like research process. My colleague Dr Jennifer MacRitchie and I are so pleased with the international acclaim and interstate uptake of this model, particularly in 1) a Queensland Health initiative where this information is available to 5,000 health staff within a training module entitled “Creative arts in paediatric healthcare: A guide for clinicians”, and 2) informing the 3,000 member organisations of the National Activity Providers Association, a peak body which establishes UK Quality Standards for Activity Provision (MacRitchie & Short, 2025). Both of these uptakes are exactly the type of impact that we hope can assist the music therapy profession into the

future. In doing so, we can extend our interprofessional work at local, national and international levels, to create and advance care for our clients and understanding of what we do as music therapists (Short & Heiderscheid, 2020, 2023). This can occur in so many ways – in discussions, presentations, placements, and publications. Connecting with each other including across professional boundaries is what keeps us going, reassures and energises us, supports and sustains us.

Annie: What are key values that have guided your work?

Alison: Aligned with my belief system, three values are key to guiding my work and my approach to work. Respect is about simple human dignity, facing each other as authentic individuals and committing to not bullying, harassing, manipulating or otherwise disrespecting each other. We are all different, we have come from different places into music therapy. Since music therapy became a graduate degree, that also means many different trainings, backgrounds, viewpoints and foundational experiences across the lifespan before starting music therapy training. As we approach difference, it is easy to think that we are right, and everyone else is wrong. But in fact, respecting each other as a community is what keeps us strong, as we collaborate and work together.

There is also an element of respect for our research which we have had to work on and extend – while at the same time we work with others and respect their work. For example, in the early years, much of our music therapy research was clinical case studies or case reports, and collectively we have had to learn qualitative, quantitative, randomised controlled trials, mixed method and even the newer research case study methodologies. We can be proud of the number of Cochrane and Joanna Briggs meta-analyses with Australian music therapy researcher participation, and at WSU we are punching above our weight with systematic and scoping literature reviews to inform the profession (Patch & Short, 2022; Stone & Short, 2023). Recently, I have challenged myself to re-think and re-work a simple case report (Short, 1996-7) into a research case study (Short, 2023b), and this has been a valuable exercise. We can use evidence, such as my personal record of over 111 publications, and similarly the research of others, to ensure that respect for our profession is enhanced and we can build on this foundation into the future. Part of respect is also accepting and valuing our differences and the contributions that we all make to the profession.

Diversity is explicitly addressed in the AMTA in and around our music therapy practice, including the 49th AMTA National Conference AMTA Conference which particularly addressed diversity (<https://www.austmta.org.au/events/2024-conference>). Diversity is about our uniqueness. It includes our backgrounds, personality, life experiences and beliefs, in fact, all the things that make us who we are. Our differences shape each of us and our perspectives on the world. When we talk about diversity, we are thinking of differences based on ethnicity, gender, age, race, religion, disability and sexual orientation. We may also have unique characteristics and experiences, related to communication style, career path, life experience, educational background, geographic location, income level, marital status, parental status and other variables that influence personal perspectives. Inclusion occurs when people feel valued and respected for their uniqueness. This leads to opportunities, access and achieving everyone's personal best and their full potential, and ultimately a sense of belonging.

Harnessing the richness of diversity is well acknowledged these days within leadership training, such as the widely acclaimed Franklin Women Researcher Leadership program which I undertook in 2021 (Franklin Women, 2025). Valuing diverse views and inputs makes a strong and creative team, able to collectively problem solve through a wide range of circumstances. These days the question is often raised: If your team is not diverse in character – why not?! Diversity happens at all levels – in our individual practices, our health and practice teams, in our collaborations, in our research, and I am also enjoying experiencing this internationally on the Council of the World Federation of Music Therapy. Together, we have many views, ideas, strategies and approaches.

Diversity is something that we have continued to infuse into both research and education at Western Sydney University. My first research position was at the Centre for Culture and Health (UNSW, 2004) with projects across Greek, Russian, Chinese, Vietnamese, Cambodian, Thai communities and more (Blignault et al., 2004), I subsequently expanded my understandings and thinking across many aspects of cultural diversity and health including both practice and education (Folagbade & Short, 2008; Sheikh et al., 2011; Short, 2019b, 2022b; Short, Honig, et al., 2022). During my time with the Centre for Culture and Health, I worked closely with the Australian New South Wales Health Multicultural Service, later leading to additional projects. One learning was about translation to other languages: it is not only about words, but also cultural understandings. For example, the popular Australian “Meals on Wheels” program of food delivery for vulnerable people – in Chinese cultures, was called, “Restaurants on Boats!” In fact, I received funding to run a collaborative Chinese Cultural Day, implemented in conjunction with the Chinese Australian Services Society (CASS), a large non-government organisation service provider. This included a wonderful day of collaborative information sharing about music therapy (for them) and about Chinese culture (for many of the rest of us), including experiences with food, dancing, music and impromptu experiential music therapy sessions (Short, 2017; see Figure 1). Beyond this, I have been delighted to be nominated by AMTA onto the Council of the World Federation of Music Therapy, representing the Australian and New Zealand region, and I am pleased to serve beside colleagues such as Indra Selvarajah, Chair of the Global Crises Intervention Commission, and indeed leader of the first Singaporean music therapy training, on this internationally diverse worldwide music therapy body.

Relating to each other with compassion is critical, including in collaborative professional organisations. Even when there may be some dissensions, compassion and kindness win the day. Unashamedly, I say that compassion and self-compassion are needed to live well and with resilience. In fact, I have been doing further training about spiritual issues, as I believe that we all need to activate our spiritual dimension to support our ongoing development and to thrive in the world. For this reason, I developed the “Resilience Corner” as a brief moment of reflection within regular the second year classes I was teaching during the pandemic, an approach which remains current with a couple stimulus slides and open discussions about a relevant topic which fits under the broad topic of “pastoral care” – and where the term “pastoral care” is now seen as a secular activity in supporting students and others (Lokhee, 2023; Lokhee & Short, 2025; Short, 2023c, 2025a). As one student said within our systematic research study of this approach:



Figure 1: Collaborative Chinese Australian Cultural Day, 2017. Alison Short with Ivan Wong, Vice-Chairperson, CASS; WSU music therapy students playing the Chinese guzheng and demonstrating percussion techniques in music therapy.

I actually also found that having that Resilience Corner in a way allowed us to sort of, be able to connect on a deeper level, even though we weren't face to face. I guess that allowed us to sort of see a little bit of each other in a different way... But get to know each other a little bit better, in terms of that. So I think it was really good to have that check in, and especially in the kind of work that we're doing is in a way like it helps set us up a bit for supervision and things like that down the track... And at the time as well, it was also really helpful to sort of, have a bit more, I feel like it did lead to more of a connection and stuff.

I have also written, presented and researched on resilience and spirituality, and I look forward to pursuing this even more into the future (Short, 2020, 2021b, 2022c, 2023c, 2024c, 2025a). My understanding is that we need to be grounded with meaning and purpose in our profession, and this is where spirituality gives benefits across a wide range of approaches and philosophies, in accepting and caring for each other in a world which exists beyond ourselves.

Annie: What changes have you observed related to music therapy in Australia?

Alison: Context makes a difference! Always in music therapy, we use music to address the context and remain flexible, taking on new ideas, approaches and initiatives. Life changes! And this was brought home to us with pandemic lockdowns, isolations, restrictions, fighting for our livelihood, our students and our clients. By nature of being humans in this world, we naturally contextualise what we do into our own time and place. We are proud to acknowledge the indigenous land on which we meet for teaching and conferences, and to think about how we serve our diverse communities in Western

Sydney and beyond. We are also very aware of the need to adapt to context, and to help students in the next stage of their music therapy careers as they are about to graduate. For this reason, our initial Research Proposal Presentation Day, now called the Research & Careers Symposium, has turned into a dual event as Careers Fair, and over time this has morphed into an important event where employers come to recruit music therapists – leading to the fact that typically most of our graduating class have job prospects in place before they have even finalised their studies. This undoubtedly reduces stress for everyone, including employers who currently struggle with finding enough music therapists in Sydney and NSW.



Figure 2: Contextualising music therapy at Western Sydney University
(Artwork: Western Sydney University, 2018)

Annie: Do you have examples of how your approaches and your values have informed and helped contextualise your clinical practice, teaching and learning, and research?

Alison: Yes, I'd like to tell you about two examples which fit with the issues/ideas that we have been talking about. The first example is about participatory music creation with Pasifika communities to understand and support engagement with antenatal care². This project was founded on a longstanding collaboration for arts and health, based around the South West Sydney Health Arts Partnership. Hospital staff within this Partnership had identified higher rates of late antenatal first visits by Pasifika compared to Australian-born women (41% versus 29%, as noted by South Western Sydney Local Health District from 2019 records), potentially affecting both mother and baby by a pathway on untreated gestational diabetes. At the same time, it was noted that music is typically a significant focus in Pasifika cultures, and after initial discussions, a collaborative team was developed, which included

² Project team: Alison Short, Neil Hall, Josephine Chow, Jacqueline Ramirez, David Kelly, Kathryn Farrell. Advisory group: Freya MacMillan, Virginia Schmied, Litea Meo-Sewebu. Research assistant: Sydney-Rella Pihema. Funding: Western Sydney Creative Collaborate Fund (\$13,800).

health staff, a WSU Social Work academic, researchers working with Pasifika communities, and a MCMT alumni research assistant. Initially, funded MCMT students undertook literature reviews to scope and understand the focus area; the ethics application completed by the team with assistance from social work students. It was found that scant materials exist about arts-based interventions in the antenatal hospital clinic setting for hard-to-reach minority group populations.

This project focused on using music to (a) collaboratively engage with and increase research understandings of Pasifika community antenatal needs, and (b) collaboratively produce cultural music suitable for the hospital antenatal waiting room, potentially inspiring a sense of ownership. The innovative methodology approach included a series of key informant interviews and focus groups, with each focus group having the dual purpose of music to support cultural comfort in speaking about issues, and group creation of music which could be played in the antenatal clinic, to change the environment and increase ownership of the space (Short, Hall & Chow, 2025). Note that the term *Pasifika* covers all people identifying with Pacific Islander and Maori cultures; this project sought to engage across the Pasifika diaspora, with Samoan, Maori, Fijian, Cook Islanders, Tongan and mixed groups.

Progress to date has included three focus group music-making sessions with mixed Pasifika cultural groups, in the context of some recruitment challenges. Recorded focus groups have been transcribed, and thematic analysis is still in progress. Additional recordings have taken place, to improve digital quality of recordings, which are still under preparation for antenatal clinic use. As one participant responded,

That's why I loved the initiative to have nice, soothing music be played while you're in the waiting area... Yeah, so it would be great to have that set ambience in the waiting room. Get the mother relaxed before she goes into her antenatal appointment. (Focus Group 3)

This feasibility pilot project serves as an example of a mutually engaged community approach to addressing health needs, and is expected to have further applications to other marginalised cultural groups who may be reluctant to engage with health care services and may be hard-to-reach, such as Aboriginal and Torres Strait Islander and Humanitarian Entrant groups, where music can act as a positive facilitator for engagement in health and wellbeing activities.

The second example is about music therapy for older inpatients in an acute setting.³ Based on a previous research relationship, a senior consultant geriatrician requested music therapy students on their final year "Independent Placement" for her hospital acute aged care unit. It was noted that admission to the hospital aged care unit can be disorientating, isolating and fearful for elderly people, and that communication and environment link to patient satisfaction and delirium prevention (Ní Chróinín et al., 2025); additional challenges of language and culture (CALD) with longer stays (22-50%); cognitive impairment and adverse events. This particular unit at Liverpool Hospital had high rates of behavioural and psychological symptoms of dementia (BPSD) and/or delirium, which was associated with substantial use of anti-psychotic medication, intensive staff supervision/observation

³ Project team: Alison Short, Danielle Ní Chróinín, Neera Vadali, the Aged Care Team on 5A, Liverpool Hospital, and MCMT Students: Amanda Low, Grace Ng.

and frequent 'Code Black' security calls. Additionally, feelings of isolation, fear and anxiety were exacerbated during the COVID-19 pandemic due to restrictions on hospital staff and visitors. Further discussions and investigations led to the realisation that most of the aged care music therapy evidence hails from residential and community settings, with limited and mixed evidence in acute settings. It was collaboratively decided that a Quality Improvement project could be supported by the Aged Care Registrar and additional staff, focusing on a patient-centred, arts-based initiative providing music therapy twice weekly via final-year music therapy students at the Liverpool Hospital acute aged care ward. In terms of approach, all patients admitted to the ward were eligible for inclusion during the designated time period; individual sessions of 5-10 minutes took place based on participant needs; and culture and language were modified throughout the session based on engagement levels. All sessions were individual, with no group sessions permitted due to COVID-19. Music therapy sessions included both active and receptive approaches, including interactive sessions with songs and guitar and the use of recorded music sourced from standard digital applications. A Quality Improvement survey was developed and formally approved in consultation with stakeholders and hospital processes, in order to assess staff and patient perceptions. The survey was available in hard copy and in six languages within this multicultural hospital context. The full eight-week music therapy program ran as planned, with the music therapy students using full protective clothing, and they were not permitted to sing. Music therapy was received by a median of 11 patients (IQR 9-12) each day, of which median 8 (6-11) were new; there were no refusals and no visitors. Amongst the ten patients who provided feedback, the mean age was 81.1 (SD 7.7), six were female, and all had some level of cognitive impairment. In addition, 19 staff members responded (12 female), comprising Registered Nurses (8), Doctors (7), Allied health (2), Assistant Nurses (2). This project won a Quality Award, in the category of *Enhancing the patient experience through Arts*, South Western Sydney Local Health District (2022), entitled, "*Music therapy for older acute inpatients*", and the winning project video can be found at the following link: <https://www.youtube.com/watch?v=7b3ZApZ8WVs>. Findings suggested that providing music therapy within an acute geriatric ward setting is a feasible and effective intervention, which promoted engagement and was well received by patients with an apparent improvement in mood. Staff felt the intervention improved patient compliance with ward care. Both staff and patients indicated that the music therapy program had improved the patient experience. Therefore, patient-centred initiatives which improve the inpatient experience, such as music therapy, deserve consideration in this context. Further information about the project has now been published (Vadali et al., 2024).

On further reflection, these two examples demonstrate many aspects of my personal context and the broader professional growth of music therapy across my lifetime. Both projects have been informed by practice experience in terms of reaching out to, and engagement with, vulnerable and aged care groups in using music for health benefits. Also, in both instances, new evidence has been generated by creating and investigating an innovative method and by creating increased evidence suitable for hospital requirements. Aspects of education within the two projects include involving current music therapy students and further extending the research capacity of music therapy alumni. Creativity is demonstrated by generating both new culturally appropriate music and a new methodological approach, and despite the wearing of personal protective equipments such as face masks and gowns, music has been used to connect and build relationships. Interprofessional aspects

of connectivity are seen to cross music therapy, the broader community and a wide range of health staff. The two projects have also fostered the building of respect through increasing both community and health knowledge and interactions, and by demonstrating and extending understandings about the role of music therapy. Further, diversity has been directly addressed through one project focusing on particular identified cultural and gender needs, within the broader context of a very multicultural hospital and health service provision area. Compassion is seen as being exercised in creating meaningful human interactions and working towards improved community health and wellbeing outcomes. Each project was adapted to identified needs within the community and applied context, including the effects of the pandemic when no visitors were permitted and specific health promotion needs within the local health service. Both projects communicated the power and potential of music to make a difference and change the experiences and outcomes of people with health needs in our community and our world.

Annie: Any final thoughts or reflections of your experiences as a music therapist that you would like others to learn from?

Alison: Before my closing thoughts and reflections: I would like to thank you, Annie, for your time and thoughts in discussing and drawing out my lifetime of experiences, some of which you may be hearing for the first time despite our longstanding collaboration! I remember with fondness the first time that you approached me and introduced yourself at Augsburg College (2011, ISMM Conference, Minneapolis) and our many subsequent collaborative discussions around the world in various locations, be it a dinner cruise in Thailand, sitting on the floor sharing sushi in Japan, over lunch in a traditional Pub in Ireland, or schnitzel in Krems, or even in Australia! Together, we have shared deeply about our music therapy experiences and communities, and sought ways to positively use a critical reflective approach to progress growth and understanding within the worldwide application of music therapy. This has been such a valuable partnership, as we have explored interprofessional issues (Short & Heiderscheid, 2020, 2023), training issues (Heiderscheid & Short, 2024; Short & Heiderscheid, 2023, 2025), clinical applications in many contexts (Heiderscheid et al., 2025) and more! (Heiderscheid et al., 2020).

Stepping back into my own perspective, and as I reflect on my journey with music therapy in Australia as one of the first group of Australian graduates, I realise that my history demonstrates active pioneering support of the music therapy profession in Australia, creating building blocks in many and diverse ways. This has included fostering the Master of Creative Music Therapy course at Western Sydney University, and in turn helping with finding an educational home at the new Music Therapy@Western Centre, an on-campus clinic dedicated to the needs of music therapy student development and of course the clients it serves, also providing opportunities for research. This innovation of the Music Therapy@Western Centre is a game-changer which is being watched around the world, with thanks to all who have been involved in its development.

In my closing thoughts, I congratulate music therapy in Australia! From humble beginnings, music therapy has grown and developed in Australia, and has been founded on the essential building blocks of a range of methods, such as working in the moment with a child to promote change using music, an incredibly effective approach. Many people have contributed pioneering work, and some

have continued with international teaching, research collaborations and consortiums. This has included the trail blazers, the educators, the people pushing the boundaries – many people have guided and inspired music therapy in Australia! In exploring and reflecting on music therapy in Australia, it has become evident that we have a rich, deep and embracing identity as music therapists in Australia, working together to advance our evidence-based, community-oriented field of practice. We are well placed with the progress we have already made, both as a national community and in our region, and we look towards further advances in teaching, research and practice.

What does the future hold? I challenge each and every practitioner to hold the music therapy profession close, to work together, and to find ways to develop into the future. Of course, there will be challenges along the way, and together we are stronger. I encourage every music therapist to live in hope – as we work towards improvements in all aspects of music therapy in Australia and around the world. Be the change! Put your life and practice where it counts – into the real world, with the real people, and with your real colleagues!

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Ελληνική περίληψη | Greek abstract

Ανασκοπώντας την εξέλιξη της μουσικοθεραπείας κατά τη διάρκεια μιας ζωής: Σκέψεις για το παρελθόν, το παρόν και το μέλλον

Alison Short | Annie Heiderscheit

ΠΕΡΙΛΗΨΗ

Η ανάπτυξη της μουσικοθεραπείας ως επάγγελμα διαφέρει σημαντικά σε παγκόσμιο επίπεδο, επηρεαζόμενη από την τοπική εκπαίδευση, την κλινική πρακτική και τις ερευνητικές πρωτοβουλίες. Η κατανόηση αυτών των εθνικών και διεθνών εξελικτικών διαδρομών είναι κρίσιμη για την συνεχή εξέλιξη του επαγγέλματος. Η παρούσα συνέντευξη συμβάλλει σε αυτή την κατανόηση εξερευνώντας την καριέρα και τις απόψεις της Alison Short, μιας εξέχουσας Αυστραλής κλινικής μουσικοθεραπεύτριας, ερευνήτριας και εκπαιδευτικού. Η χρονική συγκυρία της συνέντευξης είναι ιδιαίτερα σημαντική, καθώς συμπίπτει με την 50ή επέτειο της Αυστραλιανής Ένωσης Μουσικοθεραπείας (Australian Music Therapy Association – AMTA) το 2025, ένα ορόσημο που προσκαλεί σε αναστοχασμό σχετικά με την εξέλιξη του επαγγέλματος και τις μελλοντικές του κατευθύνσεις στην Αυστραλία. Η διαδικασία ημι-δομημένης συνέντευξης του κειμένου καταγράφει τις γραπτές απαντήσεις της Short σε μια σειρά ερωτήσεων που επικεντρώνονται στις ποικίλες επαγγελματικές της εμπειρίες. Αυτές οι απαντήσεις διερευνήθηκαν περαιτέρω μέσω διαδικτυακών συναντήσεων, που επέτρεψαν βαθύτερη συζήτηση και κριτικό αναστοχασμό. Η αφήγηση που προκύπτει αναδεικνύει βασικά θέματα που έχουν διαμορφώσει τη συμβολή της Short στη μουσικοθεραπεία, σχετικά με την κλινική πρακτική, το ακαδημαϊκό έργο, την έρευνα, την εξέλιξη της μουσικοθεραπευτικής εκπαίδευσης στην Αυστραλία, καθώς και τις ευρύτερες επαγγελματικές προκλήσεις και επιτυχίες που παρατηρήθηκαν επί πολλές δεκαετίες. Μέσα από την εξερεύνηση και καταγραφή των αναστοχασμών της Short, η συνέντευξη προσφέρει πολύτιμες σκέψεις για την εξέλιξη της μουσικοθεραπείας στην Αυστραλία και για τη σχέση μεταξύ ατομικών επαγγελματικών διαδρομών και ευρύτερης επαγγελματικής ανάπτυξης. Αυτές οι σκέψεις είναι χρήσιμες όχι μόνο για την κατανόηση του αυστραλιανού πλαισίου, αλλά συμβάλλουν επίσης στον παγκόσμιο διάλογο για τη διατήρηση και προώθηση της μουσικοθεραπείας ως ένα δυναμικό, τεκμηριωμένο και προσωποκεντρικό επάγγελμα.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

ανάπτυξη της μουσικοθεραπείας, Αυστραλιανή Ένωση Μουσικοθεραπείας, συνέντευξη

REPORT

Transient communities: The case of a refugee choir in the Catholic church of Lesvos

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ABSTRACT

For many refugees fleeing conflict in the Middle East and Africa, the Greek island of Lesvos is the first point of entry into the European Union. However, due to an agreement between the European Union and Turkey declared in March of 2016, people crossing the Aegean Sea without formal travel documents would be detained on the Greek islands until their asylum applications were examined. This bureaucratic slowdown trapped refugees on Lesvos for months and years of unknown waiting. At the same time, the arrival of refugees from various African countries led to a flourishing of the small Catholic church in the capital city, Mytilene. In 2017, a parish choir was established by Congolese refugees with the purpose of providing a refuge to members who sought a sense of community, spirituality, and normality. Through interviews, participatory observation, and polyvocal ethnography, we address the following research areas: the importance of spirituality in the lives of refugees, how participation in the choir helped them to feel a sense of community, and the use of choral singing as a form of integration. More specifically, we discuss how the refugee-initiated autonomous aspect of the choir created an environment in which each member had a personal stake in developing and caring for the choir community as a whole. As a majority of the interviewees felt that singing for God was the highest purpose, participation in this choir helped members connect to their faith while also giving a much-needed sense of purpose in uncertain times.

KEYWORDS

refugee crisis,
community music,
choral singing,
spirituality

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Jennifer Sherrill holds bachelor's and master's degrees in vocal performance and pedagogy from Northern Illinois University and North Park University. She taught and performed throughout the Chicagoland area as a jazz and classical singer for over 20 years. She directed youth and community choirs and cofounded the Thousand Mile Choir, a choir premised on representing the many musical cultures of the members.

Since 2017, she has worked with multiple musical NGOs on the island of Lesbos and on multiple occasions, has served as a temporary director of the choir at the Assumption of Mary Catholic Church, Lesbos. Jennifer is currently pursuing a PhD in ethnomusicology at the University of California, Davis. [jsherrill@ucdavis.edu] **Antonis Ververis** was born in Athens and brought up on the island of Lesbos, Greece. He studied musicology and music education at the Aristotle University of Thessaloniki, and sociology at the University of the Aegean. In addition, he received graduate degrees from Roehampton University, UK, and Lynchburg College, USA in choral education and choral conducting, respectively. He holds a PhD from Aristotle University where he carried out research on gender stereotypes in music education. His research interests also include children's vocal development and teaching methods of traditional Greek music. Since 2018, he has been teaching in the Department of Music Studies at the University of Ioannina, Greece. [ververis@uoi.gr]

INTRODUCTION

During the 2010s, Europe witnessed one of the worst refugee crises since World War II. During 2015 and the first few months of 2016, approximately 1.2 million refugees and migrants reached European shores to flee conflict, persecution, and economic hardship. Almost half of them entered Europe through Lesbos, a Greek island of 85,330 inhabitants in the North Aegean. As official statistics suggest, during the peak of the refugee crisis in 2015, 512,237 of the 856,723 refugees who entered Greece by sea found temporary shelter in Lesbos, while the number of refugees who passed through the island during the 2015-2020 period is officially estimated at 670,699 (UNHCR, 2020a). Afouxenidis et al. (2017) described the "heroic" actions by many locals, especially the residents of Skala Sykamias, who offered to help the distressed refugees reaching their coastal village by boats in August 2015. Two residents of the village were also nominated for the Nobel Peace Prize "for their efforts to save thousands of refugees" (Schoenbauer, 2016, para. 1).

Lesbos was not meant to be only an entrance or temporary passage for refugees entering the European Union. According to an agreement between the European Union and Turkey declared in March 2016, people crossing the Aegean Sea without formal travel documents would be detained on the Greek islands until their asylum applications were examined, determining whether they may be transferred to the Greek mainland or another EU country, or deported back to Turkey (Endicott, 2018). As asylum procedures have been very slow due to bureaucratic reasons, this agreement had great consequences for asylum seekers who, in reality, found themselves trapped on the islands (Jauhiainen, 2017). According to the United Nations High Commissioner for Refugees, there were approximately 19,500 asylum-seekers residing in islands of the Aegean in November 2020, of which 46% were from Afghanistan, 18% from Syria, and 7% from the Democratic Republic of the Congo (DRC; UNHCR, 2020b).

Since 2015, the arrival of refugees to Lesbos from various African countries as well as members of Western non-governmental organisations (NGO) led to a flourishing of the small Catholic Church in the capital city, Mytilene. This became apparent due to the large number of believers attending services at the once half-empty church that previously served a small local Catholic community. In 2017, a Congolese asylum-seeking musician established a choir comprising primarily Congolese refugees attending the church services. In July 2019, when he was granted asylum and left Lesbos, the second author of this report and American music educator Jennifer Sherrill temporarily filled in. In September 2019, the first author and Greek music educator Eirini Papanikolaou took on the responsibility of directing the choir, a position she held until September 2021. The overall purpose of the choir was to provide a refuge for members who sought a sense of community, spirituality, and normality, a refuge that helped them cope with the traumas of the past in addition to easing the stress of the situation they are currently experiencing.

As a topic, the therapeutic effects of spirituality and choral singing for displaced people have long attracted researchers' interest (see, for example, de Quadros & Vu, 2017; Hurly, 2019; Phelan, 2017; Raanaas et al., 2019). In most studies, choral singing is seen as a means for refugee integration into the society of the host countries. However, the case of the church choir in Lesvos is unique as its members are in a situation that could be better described with the term "in-between" due to the agreement between the European Union and Turkey. The refugees are in a place they did not intend to stay and do not know how much longer they must wait. Most importantly, until they are granted refugee status, they are officially considered "asylum seekers" and do not have the autonomy to make plans for their future.

In this report, we investigate the case of the aforementioned choir through an interdisciplinary approach that combines resources from fields such as historical musicology, ethnomusicology, choral music education, and music therapy. According to our research areas, we attempt to explore issues and better understand: (1) the reasons that prompted these refugees to establish and participate in this choir, (2) the structure and the ways through which the choir operates, (3) the selection of repertoire and its language, and (4) the liturgical colonial traditions that refugees bring with them. Furthermore, this exploration is an opportunity to explore community music-making in transient conditions, since Lesvos and the camps on Lesvos are not places considered the final home for a majority of the refugees.

BACKGROUND

Choral singing as a means of refugees' social integration

As a topic of inquiry, the therapeutic effects of choral singing for socially excluded people – that is, individuals with limited access to social, economic, political, and cultural systems (Feronas, 2005) – have long attracted researchers' interest. For example, Silber (2005) investigated a choir comprising women inmates in an Israeli prison, while Bailey and Davidson (2005) conducted research into two Canadian choirs for homeless people.

Lenette and Sunderland (2016) articulated a framework for understanding music-making projects involving refugee or asylum seekers. They outlined three categories based on the setting: (a) conflict situations in countries of origin, (b) refugee camps in exile, and (c) resettlement contexts, which is the most common case. With regards to existing literature about choral projects with refugees, one easily notes that most of them have a "top-down" structure since they are run by state organisations of the resettlement country or western NGOs. It should also be noted that the purposes or the methods employed by these projects vary greatly depending on the immigration policies that apply in each country and may focus either on the integration or assimilation of immigrants and refugees (Isaakyan, 2016). Thus, in some countries, local choral conductors prefer to recruit refugee singers to their choirs, while in other cases, refugee-specific or multicultural choirs have been established. In addition, some programs insist on the developing skills that may assist refugees in their "new life" such as learning the language and the dominant culture of the host country, while other programs celebrate diversity by performing music from the members' countries of origin.

For example, de Quadros and Vu (2017) explored the strategies employed by Swedish choral directors for the inclusion of refugees into their choirs. The researchers pointed out the Swedes' hospitality and willingness to help refugees integrate into Swedish society. However, they expressed their concern about Swedish conductors' reluctance to teach repertoire in the refugees' language, many of whom had never participated in a choir before arriving in Sweden. On the other hand, Raanaas et al. (2019) interviewed refugees singing in a multicultural amateur choir in Norway. The participants of this study maintained that the choir was important to them since it provided them a reason "to be busy" along with opportunities to socialise with others. The participants also highlighted that they were able to sing not only in Norwegian but also in their own language. Therefore, they had the opportunity to practice their skills in Norwegian and at the same time teach their language to the other members. Furthermore, they appreciated and felt proud that they could suggest songs from their own country which were then included in the repertoire of the choir. As Guinup (2020), conductor of the Tacoma Refugee Choir, suggested, choosing songs from the refugee's culture and singing in their language proved to be crucial for their recruitment and retention in the choir.

Another point of differentiation among the aforementioned cases concerned the extent to which local and refugee singers could exchange cultural elements, a note that highlights the debate between multicultural and intercultural. According to Triantafyllaki (2014), the term multicultural describes the peaceful coexistence of different cultural groups, while intercultural refers to relationships of interaction and exchange between these groups. Danochristou-Kairi (2014) argues that multiculturalism is what happens since we live in a multicultural society and interculturalism is what ideally should happen as dialogue and communication between cultures is of great importance. Even so, it is worth noting that interculturalism remains important even without the presence of the "other." When a person, who is part of the "dominant culture," grows up in a monocultural context, they might find it different to understand and accept alternative worldviews that are different from their own. A children's choir established by an NGO in Lesbos consisting of local and refugee children was a case in point. As its founders stated, "we try to gradually incorporate the refugees into our classes and on one hand to keep the intercultural character, but, on the other hand, to keep the refugees to a number not exceeding 15%" (Averof-Michailidou et al., 2020, p. 206). This quote suggests that the people of this NGO believe in the significant benefits to all participants through intercultural interaction between local and refugee children. However, assigning an ideal percentage to the number of refugees needed to maintain intercultural character can be considered problematic, unfounded, and an imposition of the dominant culture's perspective.

So far, we have referenced cases of choral projects intended for refugees, with a "top-down" structure since they are run by NGOs or state organisations. As this practice seems to be the "rule," it does not come as a surprise that there are also exceptions. Hundertmark (2018) investigated a choir in Germany founded by refugees from Syria. Through choir participation, members wished to express themselves through Syrian music and dance, contribute to cultural diversity, and promote intercultural dialogue and understanding within the wider community. This became apparent in the value the members attached to the performance of Syrian songs translated into German.

Closing this section, we would like to add into this discussion Amir's (2004) suggestion that not all refugees find it easy or are willing to share their culture with others. From her experience, some refugees place importance on the preservation of their cultural identity, while others reject it as they

seek to erase any sign of their past in order to become assimilated in the dominant culture of the host country. This proposition highlights the uniqueness of each refugee's story, along with the need for avoiding general assumptions that apply to all refugees, or individuals at risk in general.

Spirituality as a means of refugees' social integration

For this report, we use the term "spirituality" to refer to the search for higher meaning and purpose, while "religiosity" to refer to specific cultural practices and beliefs shared by a religious community. Several authors from a wide range of disciplines suggest that spirituality and religiosity can be crucial factors in the process of refugees' integration in the country of resettlement, as they provide relief from past and present traumatic experiences. Adedoyin et al. (2016) conducted an extensive review of studies "discussing how religiosity functions as an effective coping mechanism for African refugees living in the United States" (p. 97). The researchers maintained that since religiosity is central to the value systems of most African refugees, it shapes the ways in which they interact with people and their environment. Spirituality contributes to the overall well-being of refugees who are healing "both the physical body and the mind from post-traumatic experiences" (Adedoyin et al., 2016, p. 103). Similarly, a study by Abraham et al. (2021), in which the participants were 63 adult female Eritrean refugees living in asylum reception centres in Norway, suggested a strong correlation between refugees' religiosity and spirituality and overall quality of life. It should be noted that spirituality may be helpful in assisting refugees of all religions and spiritual practices. For example, Kirmani and Khan (2008) investigated the contribution of a Muslim faith-based organisation assisting refugees. As the researchers maintained, for many refugees – irrespective of religion – the inability to participate in religious and cultural rituals can further intensify the pain and trauma of displacement they already are experiencing.

The existing literature about refugees' integration also notes cases where religiosity was combined with music. Hurly (2019) investigated the cases of three former refugee African women who resettled in Canada. As she observed, faith, church, and church activities seemed to play an important role in the women's lives and leisure. Michelle, whose country of origin was the DRC, suggested that church going and singing in a church choir helped her find relief from the daily problems of life and the traumatic memories of her past, noting:

You feel happy when you sing. It helps me through. I forget about all the challenges and my mind is focused. You feel a connection in your brain when you are singing spiritual songs. You feel like you're talking to God. (Hurly, 2019, p. 6).

Phelan (2017) explored the case of a choir established by asylum seekers in Ireland who were mainly from the DRC. This choir differs from all the cases mentioned in the previous section as it focused on choir member needs for spirituality and expression of their religious faith. Thus, apart from its numerous recordings and appearances in various music events, the choir participated regularly at the Sunday Mass of the church which provided space for its rehearsals. One could assume that in this case, religion was a factor assisting refugees in their social integration since they were practicing

Catholics who gained asylum in a country where Catholicism is the predominant religion. Indeed, participants suggested that being in the church made them feel that “they were where they belonged,” even while pointing out the liturgical differences between Catholic churches in Ireland and the DRC. As one member remembers, “it was fascinating that first Mass because it was nothing like I had ever witnessed. I didn’t understand anything, not even the ‘Our Father’ which I grew up saying every morning” (Phelan, 2017, p. 254). These differences may not relate only to language or liturgical order. For example, Facci and Cosentino (2018) referred to the “musical” difficulties which a Congolese priest and musician encountered when he decided to study Gregorian chant in Rome. The main difficulty concerned the fact that though he had been used to playing music solely by ear, unaided by notation, the unfamiliar sounds of the eight modes of chant presented an aural challenge. Similarly, an African refugee living in the state of Kentucky, mentioned in Gichuru’s (2019) study: “My wife wanted to sing in the choir. They only use books [music notes] and if you do not know that, then you cannot sing. So, my wife could not sing in the choir” (p. 105). This comment indicates that choral conductors in countries of refugees’ resettlement need to make adaptations and experiment with methods and unfamiliar practices if they wish to integrate refugees into their choirs.

THE PROJECT

Our exploration is based on ethnographic data including contextual field notes, semi-structured interviews/conversations with five choir members, and autoethnographic material and reflections from August 2019 until July 2023, during which two of the three researchers [E.P. and J.S.] served as directors of this choir at different times. In this report, we present data obtained mainly from interviews with the participants, while the rest of the ethnographic material was used for data triangulation purposes. At the time the interviews were held, all participants were adults with a legal residence permit, at least a temporary permit in the case of asylum seekers. No ethical approval was required by any governmental or other organisation, but we considered the potential ethical implications of our project in detail. All participants were members of the church choir at the local parish, and we informed them about our project. They had opportunities to ask questions and choose whether they would like to participate in the project.

As Smith (2009) pointed out, researchers wishing to conduct research with marginalised populations such as refugees should take into consideration multiple factors: (1) the participants’ vulnerable position throughout the period of crisis in their country of origin, (2) their migration, resettlement, and adjustment, and (3) their level of vulnerability in the receiving country. Therefore, we respected some of the informants’ request to not include their narratives in the study. Additionally, in order to protect their anonymity, we have used pseudonyms instead of the interviewees’ real names. As our concern was with the comfort of those we interviewed, we audio-recorded the interviews but put aside our pens and paper, creating space for the interviewee to lead the conversational narrative.

The interviews took place between April and July 2021, and the interviewees consisted of five choir members, of which three originated from the DRC and two from Cameroon. According to Gorashi (2008), most refugees are reluctant to talk about traumatic experiences in their past, preferring to bury them instead of being reminded of them. Nevertheless, this did not apply in the present project, since

the participants were asked to speak more about their present and future dreams, and less about their past.

Although most of the participants spoke English, the interviews were conducted in French, the language in which participants were able to express themselves more comfortably. Led by our research areas mentioned above, we posed some of the following questions to the interviewees:

- How important is music and spirituality in your life?
- Do you perceive the choir as a means of integration into the host country or as a “window to your home”?
- Have you noticed any differences (liturgical, musical cultural, etc.) between the Catholic church in Lesvos and your country of origin?
- Is choral singing a part of your future plans?

With regards to data analysis and presentation, we decided to adopt methods of polyvocal ethnography, seeking to decolonise the knowledge presented in this report. This positions our voices as only a few among the many and privileges the voices of our interviewees (Ndaliko, 2016). To this end, we present our interviewees as quoted individuals rather than a homogenous collective whole. As our aim was to highlight the uniqueness of each participant’s personal story, we avoided procedures that could lead to the quantification of data (Kiriazzi, 2011). Finally, through reflexive anthropology (Abu-Lughod, 1990), we found that our own personal complex interactions within the church and choir informed the shape of this report. To that end, we close this section with a short passage in which Eirini (E.P.), the last director of the choir, reflects on her experience. Since Eirini is one of the authors of this report, her thoughts are presented in first person.

Jonathan

Jonathan, a refugee from the DRC, was 41 years old at the time of the interview. A father of five children and a mechanical engineer, he arrived in Greece in May 2019 facing serious health problems. In October 2019, his asylum application was approved by the Greek state and, despite many difficulties, he decided to stay in Mytilene, a place for which he felt great gratitude.

Mytilene for me, it’s like my family, my parents, my country. I came here illegally, and they accepted me. I was ill and they helped me get better; I had an operation and now I am fine. Now I can walk again. I would like to live here but I need a home, my home, and a job. I don’t want to go to Athens. I don’t like big cities, but I have to be patient.

Jonathan, who had been participating in choirs since his childhood, associated choral singing with religion and his Catholic faith, suggesting that most choirs in his country were church choirs. However, he stated that he would not mind learning to sing secular repertoire or many different languages as he likes “learning new things.” Furthermore, he would be interested in sharing his culture with other members by teaching them songs in Lingala, the dialect he speaks.¹

¹ In Democratic Republic of Congo there are four main dialects: (a) Lingala, (b) Tsilumba, (c) Kigongo, and (d) Swahili.

In his narrative, Jonathan highlighted the importance of the choir, which helped him perform his religious duties, socialise with others, and “feel like home” since he always sang in a choir when he was in the DRC.

In Congo, I used to sing in Sunday Masses as a church choir member. When I arrived in Lesvos and started living in the camp, my friends, who had already been here for a long time, informed me that there is a Catholic Church where a Sunday Mass takes place every week. The first Sunday that they invited me to attend the Mass was a real “opening” for me. Because, from the day I arrived here, I didn’t have any opportunity to pray, and I felt isolated and alone. In the church, I was given the opportunity to pray and talk to other people. I got back my voice, my pride, and my Catholic life. I was really happy.

Although singing in this choir reminded him of his home, he also noticed some differences between the small Catholic Church of Mytilene and his church in Congo.

There are not so many differences, except that the church [in Congo] is much bigger, and the Mass lasts longer, perhaps three hours. Everybody is animated. There are people who dance, others who sing... there is the choir and the musicians. It’s really alive. Here, we must watch always the time and finish in one hour.

Jonathan also referred to the difficulties he faced when asked to sing in Greek. However, he maintained that this would help him in the process of learning the Greek language, a crucial skill for his integration into Greek society.

Singing in Greek was very difficult. I couldn’t understand anything. I couldn’t even read the lyrics. I was just moving my lips. But it was something that made me happy. I saw singing in a new language as a challenge. This was also the moment I realised that I need to learn this language as this will help me in everything; to understand the songs we sing in Greek, perhaps to read in Greek in the church, and to integrate myself.

Finally, Jonathan referred to his voluntary involvement in the activities of a local NGO which assisted refugees, his “brothers and sisters” whom he was unable to help when he was facing health problems. At the end of the interview, he wished to continue helping those who are in need and keep singing in the choir as he wanted to become “a member of this community and improve himself.”

Mary

Mary, a 26-year-old asylum seeker from Cameroon, entered Greece about two years before the time we interviewed her and had previously worked as a hairdresser. Being an orphan from an early age, she was raised by the priest from the parish where she received her first communion. Therefore, being in

a Catholic church reminds her of her home and her family back in Cameroon. “God is my father (*mon papa*) and the church is my family. Wherever I am, I never feel alone”.

Mary's love for music and singing prompted her to join the choir. She did not mind singing in languages other than hers: “Music is my passion. I like singing in any language, but especially in English.” Our interview with her took place during the COVID-19 lockdown, a period in which she realised how important her choral participation was for her daily life. “I have nothing to do. I sleep, I wake up, I eat. It's only that. Every day the same thing. I don't even have a job.”

Closing her interview, Mary expressed her hope that Greece, and Europe in general, will treat refugees in a better way: “I hope that Greece will accept us, the refugees, especially those from Africa. Because we are peaceful. We don't like creating problems and if we are given the chance, we can offer so much in this society.” Days later, Mary's asylum application was approved, and she left Lesvos.

Henry

Henry, a 33-year-old asylum seeker from Cameroon, studied Agriculture Science in his country but was forced by his family to come to Europe in order to work and assist them financially. As his asylum application had been denied, Henry felt great insecurity about his future. Although he used to help the priests of his church during the masses, Henry had never been a choir member before his arrival to Greece. Despite his inexperience in choral singing, he decided to try. As he said,

The choir and the church helped me a lot. It's a great opportunity to meet new people from other countries and make new friends... but singing for God makes me happy too. It's a relief and a joy. In general, spirituality is something very important for everyone's life, especially for my life.

In addition to singing in the choir, he served as a volunteer in an NGO which helped refugees. At the end of the interview, he made a wish for the future: to learn the Greek language and to have a “normal” life in Greece.

I would like to stay here, because Greece is a big and beautiful country and there are so many nice people. I don't feel so insecure here as in Cameroon. So, I will be really happy if I manage to stay here and live in this country.

Robert

At the time of his interview, Robert, a 41-year-old asylum seeker from the DRC, had already been in Lesvos for almost five years as his asylum application had been denied several times. However, he did not seem to lose hope and faith. Although his parents were Catholic Christians, Robert became a Protestant like his grandfather. Thus, he was familiar with both liturgical traditions and had been a member of several choirs from his early years. In addition to the church choir, he also participated in a community multicultural choir and a music group created by refugees. During his stay in Lesvos, he also took both Greek and English language lessons and served as a volunteer in an NGO that provided help to refugees.

Robert noticed several differences between the Catholic Church in Lesvos and his church in Congo:

The church there [in Congo] is so big and the choir has many members. Sometimes we had five rows of seats only for the choir members. The choir must have many members so that we can have all four voice parts; soprano, alto, tenor and bass, and singers can really support them.

He also referred to the ensemble that accompanied the choir in his church, in which there were various instruments, such as the piano, keyboards, guitars, electric guitars, saxophones, trumpets and percussion instruments like tam tam and maracas.

According to Robert, singing, especially for God, is very important for him. As he said, “singing for God is like praying twice.” In addition, he acknowledged the opportunities he had to socialise with others thanks to his involvement in music activities:

I don't know what I could have done if I wasn't singing. Imagine... Could I stay for four years in a corner just waiting for the documents? No. I sing, I rehearse and that gives me the pleasure to forget all my problems and the stress I feel. Furthermore, music has offered me a really big family and a lot of new friends.

At the end of the interview, Robert expressed his desire to continue singing in choirs and wished that the church choir in Lesvos would continue its operation and have many members one day.

Jacob

The last choir member we interviewed was Jacob, a 26-year-old asylum seeker from the DRC. Jacob studied Computer Science and he has been singing in choirs since his childhood. He arrived in Lesvos in October 2019 and until the time our research took place, he had not been granted asylum.

Although Jacob attended Sunday mass every week, it took him three months to decide to participate in the choir. As he said, “he had his doubts”:

In the beginning I only watched the choir singing during the Mass. I convinced some friends to participate in the choir... but I had my doubts. Some months later, I realised that I should start singing again for my God. And this is how I joined the choir.

Jacob also noticed some differences between his church in DRC and the church in Lesvos. First, in the DRC there were three different masses each Sunday: one in French, one in Latin, and one in Lingala. In all cases, there were choral ensembles performing in the language of each mass. He also mentioned that they sang the whole hymns, while other people were dancing – especially during the *Gloria*, no matter how long it took. Furthermore, as priests did not have a stable income in Congo, people offered them goods such as food, water, oil, paper, or anything needed in their daily lives.

Singing for God was important for Jacob and was the main reason prompting him to join the choir in Lesvos. He found the idea of singing in a non-religious choir interesting as it was an unusual concept to him. As he said, "If I don't sing for God, who will I sing for? [...] Without God, I wouldn't know even who I am. He is always with me..." At the end of the interview, Jacob referred to problems he faced in his daily life in Lesvos and wished that the choir would continue to exist, suggesting ways through which it could improve even more.

I know it's very difficult to keep this choir alive, because everybody is leaving to find a true life. However, I would love to come back one day and see that it still exists. I will feel nostalgic, listening to the new members singing will make me happy. It's you, Eirini, who must take care of this.

Eirini's reflection

After Jen [co-author, J.S.] passed the director's torch to me in September of 2019, I became the director of the refugee church choir in my hometown, Mytilene. Before the COVID-19 pandemic, we rehearsed twice a week and participated regularly in the Sunday Mass, in addition to ceremonies such as funerals or celebrations, like the Feast of Saint Valentine.

Directing this choir proved to be a challenge since everything was new for me: the church, the hymns, the music, the African culture, the daily struggles of a refugee's life. Initially, I struggled with my French and had to overcome my fear that the singers would not accept me since I was white, Greek, and Orthodox Christian, while their founding director was Congolese. However, I soon realised that the exact opposite was happening. They were actually worried that I would not accept them, and they showed great respect towards me. They always helped me by carrying and passing out song books to the rest of the choir and they worked hard to sing the hymns correctly and beautifully.

In the next two years that I conducted the choir, several singers passed through Lesvos. They came to the church and joined the choir before eventually moving on to Athens, Thessaloniki, or even farther to France or Belgium. Often, many of them were unable to say "goodbye" as they had to leave immediately or secretly if their asylum application had been denied. Making plans for such a choir proved nearly impossible as many times I had to move away from my initial plans in order to adapt to the unpredictable situation. It was heartbreaking for me every time I realised that I could possibly never see someone again when they were unexpectedly absent from rehearsal. I would ask "where is he/she" and the remaining singers would answer "he/she is gone." But I soon realised that this was a positive move forward for them. I simply had to wish those leaving "good luck" and continue on with the others.

Six months after I started working with the choir, we had already developed a relationship of mutual trust to an extent that whenever the singers had a problem, they felt comfortable enough to discuss it with me. Although instability and temporality were main features of this group since its members were changing frequently, the choir felt more like a family for me. A singer who discussed his problems with me, once said, "You are our *maestra*. You take care of us. So, you are the mother of this family, and we trust you."

Directing the Catholic choir of Lesvos helped me broaden my horizons as I learned about the Catholic religion and music as well as the African cultural connections to God. I also learned the

important skills of musical flexibility when last minute changes are necessary, and conducting a choir in which we do not all speak the same language. Most importantly, I met my husband through the choir and am now a mother. I and my new family attend church almost every Sunday and singing for God is now connected to my everyday life.

DISCUSSION

As we have already pointed out, the case of the choir in Lesvos presented some unique features differentiating it from other choirs or music projects that involved refugees. Since its members were in a place where they did not know how long they were going to stay, the element that characterised all their efforts was that of the temporary, a fact which made us consider this choir as a transient community. This became apparent in Eirini's reflection as well as in the singers' narratives from which only one expressed his will to stay permanently in Lesvos, a place for which he felt great gratitude.

Another point of interest was that although the choir operated in the framework of an official organisation, the Catholic Church of Lesvos, it was established by African refugees primarily for African refugees. Our case shared many common elements with the church choir that Phelan (2017) investigated in Ireland, which was also established by Congolese refugees. In both choirs, the main factor that prompted singers to join was their need for spirituality and their will to express their religious faith through choral singing. We should mention that both cases differed significantly from the choir that Hundertmark (2018) explored in Germany whose members, all Syrian refugees, highlighted its importance as a means of expressing themselves through their culture, contributing to cultural diversity, and promoting intercultural dialogue and understanding within the wider community. In our exploration, the singers did not appear to express such feelings, possibly ignoring the fact that Catholicism is a minority in Greek society, and thus, as members of the Catholic Church of Lesvos, they formed "a minority within a minority."

The church, with a pre-crisis membership ranging before refugee crisis from 10 to 20 members, had already been a minority in Lesvos and had attempted to culturally align with the Orthodox Church in order to in order to feel welcomed on the island. An example of this is the shifting of the Easter date from the Gregorian calendar to the Orthodox calendar. By hosting Masses in French instead of Greek and allowing a place for refugees to worship in a way that is not culturally homogenous, the church risked drawing the negative attention of the local population. However, since the Masses that the refugee choir sang for were attended predominantly by refugees, the precarious positions of the refugees within the Catholic Church and the church within an Orthodox Lesvos were not obvious.

This refugees' preference for attending services in French can be attributed to the similarity, in melody and lyrics, of the French hymns they sang in Lesvos with the hymns of colonial origin they sung in their home parishes. This finding could be useful particularly for music therapists working with refugees, whose aim is to assist their patients in discovering and expressing themselves through "their own authentic voice" (Amir, 2004). However, the participants also referred to some differences they observed between their church back home and the church in Lesvos. These regarded the small size of the church and its choir, along with the short duration of the masses in Greece, while in their home countries, singing in church was accompanied by multiple music instruments (such as piano, keyboards, guitars, wind and brass instruments and percussions) and dance.

The singers' familiarity with the form of the Mass and means of worship in the Catholic Church of Lesvos may justify the fact that they considered their participation in the choir more as a continuation of their previous life, and less as a means of integration into Greek society. As a key factor that led them to join the choir, all five participants mentioned their need to perform their religious duties, exactly as they did back home, a fact which made them feel joy and temporary relief from the difficulties they had to overcome. It should be noted that for all participants, spirituality and religiosity possessed a central place in their lives while they were still in their homeland. Furthermore, participants referred to factors that typically lead amateur singers to join community choirs, such as their love for music and singing, and the opportunities that choirs provide for socializing with others.

CONCLUSION

In answering our initial research questions, we learned from our interviewees that though the celebration of the Mass in outward expression is different from that in their countries of origin, the singers in the Lesvos Catholic choir connected to one another as a family and also were able to connect to the God of their childhood homes. Participation in this choir gave a much-needed sense of purpose during an extended stressful liminal period while also providing an opportunity to learn new languages and music, thus aiding in the integration of the singers into the wider community. In support of the research into spirituality as a coping mechanism by Adedoyin et al. (2016), a majority of the interviewees felt that singing for God was the highest purpose for making music. God brought them to the choir and the choir gave them family. As a refugee-initiated group, the choir created an environment in which each member had a personal stake in developing and caring for the choir community as a whole. Because the choir had been formed by the refugees rather than through a larger NGO, the organisation of the choir was better able to meet the specific emotional and musical needs of those participating. Finally, all of the interviewees planned to continue choral singing in the future, taking their faith, community, and culture with them wherever they may go.

CODA

As these lines were being written in July 2023, the refugee choir of our project has continuously adapted to the unpredictable circumstances affecting the lives of the singers. These adaptations are attributed to the significant reduction in the number of refugees on the island combined with the governmental decision to establish a closed refugee camp away from the city of Mytilene. At present, there are fewer singers in the choir than before and the director, Papanikolaou, had relocated to Athens. Despite this, the choir continues making music for masses under the direction of a Congolese asylum-seeker. Additionally, it is worth mentioning that the first director and many of the choir members who passed through the Catholic Church of Lesvos, upon arrival in Athens, created a similar but larger choir in a Catholic Church in the city centre. There are also alumni members from the choir on Lesvos who are now singing and playing in churches in Paris and Berlin.

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Ελληνική περίληψη | Greek abstract

Προσωρινές κοινότητες: Η περίπτωση μίας χορωδίας προσφύγων στην Καθολική εκκλησία της Λέσβου

Ειρήνη Παπανικολάου | Jennifer Sherrill | Αντώνης Βερβέρης

ΠΕΡΙΛΗΨΗ

Για αρκετούς πρόσφυγες που διέφυγαν των συγκρούσεων σε Μέση Ανατολή και Αφρική, το νησί της Λέσβου αποτέλεσε πρώτο σημείο εισόδου στην Ευρωπαϊκή Ένωση. Ωστόσο, ύστερα από συμφωνία μεταξύ Ευρωπαϊκής Ένωσης και Τουρκίας τον Μάρτιο του 2016, άτομα που διασχίζουν το Αιγαίο χωρίς επίσημα ταξιδιωτικά έγγραφα κρατούνται στα ελληνικά νησιά έως ότου εξεταστούν οι αιτήσεις ασύλου τους. Αυτή η χρονοβόρα γραφειοκρατική διαδικασία παγίδευσε τους πρόσφυγες στη Λέσβο για μήνες ή και χρόνια, με άγνωστη διάρκεια παραμονής. Ταυτόχρονα, η άφιξη προσφύγων από διάφορες αφρικανικές χώρες οδήγησε στην άνθηση της μικρής Καθολικής εκκλησίας στη Μυτιλήνη, την πρωτεύουσα του νησιού. Το 2017, ιδρύεται ενοριακή χορωδία, αποτελούμενη από Κονγκολέζους πρόσφυγες, η οποία αποτέλεσε καταφύγιο για όσους αναζητούσαν ένα αίσθημα κοινότητας, πνευματικότητας και κανονικότητας. Μέσω συνεντεύξεων, συμμετοχικής παρατήρησης και πολυφωνικής εθνογραφίας, εξετάζουμε τα ακόλουθα ερευνητικά θέματα: Τη σημασία της πνευματικότητας στη ζωή των προσφύγων, το πώς η συμμετοχή στη χορωδία τους έχει βοηθήσει να αισθανθούν ότι ανήκουν σε μία κοινότητα, και πώς μπορεί να αξιοποιηθεί το χορωδιακό τραγούδι ως μέσο ένταξης. Πιο συγκεκριμένα, συζητάμε πώς ο αυτόνομος χαρακτήρας της χορωδίας, που δημιουργήθηκε με πρωτοβουλία των προσφύγων, συνετέλεσε στη δημιουργία ενός περιβάλλοντος όπου κάθε μέλος συνεισέφερε προσωπικά στην ανάπτυξη και τη φροντίδα της κοινότητας ως ολότητα. Καθώς για την πλειονότητα των ερωτηθέντων το να τραγουδούν για τον Θεό αποτελούσε στόχο υψίστης σημασίας, η συμμετοχή στη χορωδία τους βοήθησε να συνδεθούν με την πίστη τους και παράλληλα, να έχουν ένα αίσθημα σκοπού, στοιχείο αναγκαίο κατά τις στιγμές αβεβαιότητας που βίωναν.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

προσφυγική κρίση, κοινοτική μουσική, χορωδιακό τραγούδι, πνευματικότητα

REPORT

The process of the legislative regulation of the music therapy profession in Cyprus

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ABSTRACT

On 5th May 2022, a law on the registration of music therapists and other related matters [N.68(1)2022] was unanimously ratified by the House of Representatives in Cyprus. This report describes in detail the process that the Cyprus Music Therapy Association (CyMTA) followed in order to achieve legislative regulation of the music therapy profession. Before analysing the regulation process, we present a short introduction to Cyprus' history to clarify the particular political situation of the country. Then, we provide a historical review of the development of music therapy and the music therapy profession in Cyprus. Finally, we describe the Cypriot constitutional framework, as the statutory consolidation of the music therapy profession in Cyprus was mainly achieved through constitutional procedures.

KEYWORDS

Cyprus,
music therapy law,
statutory
consolidation,
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CYPRUS: A BRIEF HISTORICAL OVERVIEW

Cyprus, officially called the Republic of Cyprus, is an island country in the eastern Mediterranean Sea. It is the third biggest island in the Mediterranean, and is east of Greece, south of Turkey, west of Syria and north of Egypt (WorldAtlas, 2018). Throughout its long history and due to its strategically

important location, Cyprus had been conquered by a number of foreign powers, the last one being the British Empire from 1878 until 1960 (Campbell, 2003).

The year 1960 was a landmark in Cyprus' long history because for the first time, it became an independent and sovereign state for all the inhabitants of the island, where about 78% Greek Cypriots, 18% Turkish Cypriots, 1% Maronites, Armenians and Latins, and 3% others lived. However, disagreements over the 1960 constitution led to intercommunal conflict between Turkish Cypriot and Greek Cypriot communities and the withdrawal of Turkish Cypriots into enclaves in 1963 (Countrystudies.us, 1963).

In July 1974, a coup d'état, backed by the military junta in power in Greece, overturned the democratically elected government, forcing the Cypriot President to flee (Mallinson, 2005). This action precipitated the Turkish invasion of Cyprus on 20th July, which led to the occupation of the present-day territory of occupied Cyprus (north part). The Republic of Cyprus is de facto partitioned into two main parts: the area under the effective control of the Republic, located in the south and west, comprises about 58% of the island's area; and the north (occupied Cyprus), administered by the self-declared Turkish Republic of Northern Cyprus, covers about 37% of the island's area. The remaining 5% of the island' is covered by the United Nations (UN) buffer zone and the Sovereign Base Areas (SBA) of Akrotiri and Dhekelia, which remain under the United Kingdom's control (McArthur et al., 2018).

After a long and turbulent political journey, on 1st May 2004, Cyprus joined the European Union. Under the terms of its accession, the entire island is technically considered to be a member of the European Union, despite its continued division and the fact that the government of the Republic has no effective authority over the northern part of the island (Ker-Lindsay et al., 2011).

Based on this brief historical overview, we clarify that when we refer to Cyprus in this report, we mean the officially recognised southern part only. Thus, we focus on the process towards the legal recognition of the music therapy profession as practised in the areas controlled by the official government of Cyprus.

MUSIC THERAPY IN CYPRUS: HISTORY AND BACKGROUND

Music therapy in Cyprus started its life in 1987, when Anthi Agrotou, the first Cypriot music therapist, returned from her music therapy studies from the United Kingdom and created the first music therapy work position at 'Nea Eleousa', an institution for people with severe learning disabilities.

In 1999, a new 'Law on Special Education' [N.113(1)/99], was put into practice and for the first time, the Ministry of Education and Culture employed music therapists in public schools for Special Education. A major contributing factor was that during the preparation for the legislation, Agrotou was a member of the research committee, "Special Committee for Studying of Ways of Providing Assistance to Children with Special Needs", which was appointed by the Ministry of Education and Culture (Ministry of Education and Culture, 1992). The committee's report, delivered in the autumn of 1992, formed the basis of Law 113(1)/99, which included most of the children with learning disabilities in regular schools (Agrotou, 2008). The inclusion of music therapy in the therapeutic programme of public schools for Special Education was a very important step, as it represented the first substantial recognition of the music therapy profession in Cyprus.

Since then, jobs were created in institutions for profoundly learning-disabled children and adults, such as psychiatric units and elderly care homes. However, the majority of music therapists in Cyprus work with children and adolescents with learning disabilities in public schools for Special Education or as self-employed music therapists in the private sector.

In 2023, the number of qualified music therapists in Cyprus reached about 35. All of them are graduates of educational programmes (bachelor's or master's level) from abroad such as the U.S.A., the United Kingdom, Germany, Finland, and Austria, as there is no music therapy training programme in the country. It is worth noting that from 2008 to 2016, music therapists who were graduates of postgraduate programmes were excluded from the employment contracts of the Ministry of Education and Culture and could not work in public schools for Special Education. This was attributed to the fact that The Ministry of Education Employment Contracts require a Bachelor's Degree in Music Therapy.

The multiplicity of approaches as well as the exclusion of music therapists with a postgraduate degree generated the need for an official registration, in coordination with state legislation, for all practising music therapists in Cyprus. In order to address this need, the Cyprus Music Therapy Association (CyMTA) was formed in 2010 to promote music therapy and make suggestions towards state legislation that would govern the registration of music therapists and other relevant issues. Other landmarks in the development of music therapy in Cyprus were in 2011, when CyMTA became a member of the European Music Therapy Confederation (EMTC) and in 2020, when CyMTA joined the World Federation of Music Therapy (WFMT).¹

THE CONSTITUTIONAL CONTEXT OF CYPRUS

Cyprus is a republic with a presidential system of government, where the President of Cyprus is both head of state and head of government, and executive power is exercised by the government. Legislative power is held by both the government and the parliament (House of Representatives), and the judiciary is an independent body of the state.

Accordingly, the House of Representatives is the legislative body. Its legislative function consists of establishing, amending, or abolishing rules of law. Proposed legislation is submitted to Parliament in the form of draft laws (i.e., legislative proposals). The right to propose laws belongs to the parliamentarians. Every draft law submitted to Parliament must be accompanied by a statement of reasons, i.e., an explanatory report that accompany the adoption, amendment, or repeal of relevant legislation.

Aimed at carrying out parliamentary work in a more orderly manner, the Constitution and the House Rules allow for the setting up of committees, the composition of which is decided by the Committee of Selection. Political party groups in the House are duly represented on each parliamentary committee. Parliamentary committees are divided into standing committees, corresponding to the respective Ministries and other temporary, ad hoc, or special committees. In our case, the Committee on Health Affairs was responsible for investigating the legal recognition of the music therapy profession.

¹ Cyprus Music Therapy Association: www.cymta.org

THE PROCESS TOWARDS THE LEGISLATIVE REGULATION OF THE PROFESSION OF THE MUSIC THERAPIST²

The attempts to legislate the music therapy profession began in 2010, by the so-called "Music Therapy Initiative Group"³. The first step in this effort was the drafting of a legislative proposal in collaboration with a lawyer. Then, this legislative proposal and an explanatory report were handed in to the Committee on Health Affairs. In 2013, the CyMTA submitted another legislative proposal to the Committee on Health Affairs. However, all negotiations regarding legislation had been unsuccessful. The process did not proceed mainly because the Cyprus Professional and Scientific Psychological Association (CyPSA) objected, arguing that music therapists are not sufficiently qualified to take on mental health cases. They based their argument on the fact that most music therapists were graduates of two-year postgraduate programmes rather than degrees, ignoring the fact that music therapy was primarily taught in this form in Europe.

In 2020, the CyMTA worked urgently on the legislation. Some of the reasons that immediately necessitated the legislation were: 1) the growing number of music therapists in the country; 2) the increase in demand for music therapy services; and 3) the many complaints about people who presented themselves as music therapists when they were not and worked with vulnerable groups. Unfortunately, due to the lack of legislation, the Association could not intervene, so these people acted unchecked, and 4) the need for the music therapy profession to be included in the National Health System (GESY). Related health professions have already been included in GESY. Only the music therapy profession has been excluded (see Appendix).

During the period from February 2020 to March 2021, CyMTA council members approached parliamentarians (from different political parties) who were members of the Committee on Health Affairs in order to educate them about the importance of regulating the profession of music therapy in Cyprus. Consequently, in March 2021, the Committee on Health Affairs arranged for the first official meeting on music therapy legislation and invited relevant stakeholders to participate, including the Cyprus Ministry of Health, the Cyprus Council of Recognition of Higher Education Qualifications (KY.S.A.T.S.)⁴, the Cyprus Ministry of Education, Sport and Youth (M.O.E.C.), the Ministry of Labour, and Social Insurance (M.L.S.I.), the Legal Services, and the CyPSA.

In the first meeting, all the relevant stakeholders expressed their views and concerns about the legislation to the Committee on Health Affairs. Firstly, the representative from the M.O.E.C. supported the necessity of the legislation by stating that: "music therapists have been working for 20 years at public schools for Special Education and it is widely acceptable that they have played a significant role to the therapeutic process of the students with learning disabilities" (House of Representatives, 2021). Secondly, KY.S.A.T.S. pointed out that the legislative proposal should include the same recognition criteria of KY.S.A.T.S. regarding higher education qualifications. Thirdly, the CyPSA raised some concerns mainly about the referral process and the definition of music therapy. CyMTA

² The facts are confirmed by the report of the Parliamentary Committee on Health Affairs, "About Registration of Music Therapists and for Other Related Matters Law of 2021" (see Republic of Cyprus, 2022a).

³ People of this group later created CyMTA.

⁴ KY.S.A.T.S. is the competent authority of the Republic of Cyprus that recognises higher education qualifications.

submitted a memorandum (see Appendix), accompanied by letters of support from doctors, relevant associations, and health facilities that provide music therapy services. At the end, the president of the Committee on Health Affairs announced that the regulation of music therapy profession is important and assigned the configuration of the law to the Legislative Department of the Ministry of Health.

The next important step in the recognition process was the configuration of the law in collaboration with the Legislative Department of the Ministry of Health. CyMTA council members worked closely with the responsible officers from the Ministry of Health and adjusted the legislative proposal following the standards of relevant health professions' laws and regulations. A crucial point in the configuration process of the law was the determination of the academic qualifications which a music therapist should obtain in order to be registered, the definition of music therapy, and the registration board.

Reaching an agreement about the academic qualifications was very difficult since all music therapists in Cyprus come from different training courses. After examining in detail the academic standards of the educational programmes of the majority of music therapy graduates in Cyprus (United Kingdom, Germany, Finland and USA), CyMTA and the legislative department of the Ministry of Health agreed to the following (see Cyprus Law, 2022):

1. "A person is entitled to be registered if he satisfies the Board that he holds a) a university degree or equivalent in music therapy⁵ recognised under the Law on the Recognition of Higher Education Degrees which includes a supervised practical training consistent with the Board's criteria or b) university diploma or equivalent degree in music therapy not recognized under the Law on the Recognition of Higher Education Degrees, which includes supervised practical training that is consistent with the criteria of the Board and a valid license to practice music therapy profession, which is issued by an EU member state or a third country where the profession is legislated" (pp. 857-858)⁶.
2. Music therapy is defined as "the health profession which utilizes evidence-based music therapy practices, which employ the use of music and its elements, in order to achieve individual therapeutic goals for the improvement of social, communication, learning, mental, emotional and physical health and functioning" (p. 854).
3. "The Registration Board will be composed of seven representatives: (a) three registered music therapists who work at the Ministry of Education and practise the profession for at least 3 years, (b) three registered music therapists who work in the private sector and practise the profession for at least 3 years, and (c) one officer from the Ministry of Health" (p. 855).
4. The registered music therapists shall provide evidence of adequate Continuing Professional Development every two years (30 hours minimum).

⁵ Since 2016, KY.S.A.T.S evaluates Master's degrees in Music Therapy through an Equivalency Formula: Bachelor's (in Music) + Master's in Music Therapy = Bachelor's in Music Therapy. This was attributed to the fact that The Ministry of Education Employment Contracts require a Bachelor's Degree in Music Therapy.

⁶ In this case, music therapists who are graduates of postgraduate programs (Master's) and hold a valid license to practice music therapy from a country where the profession is legislated (e.g., United Kingdom) will be entitled to be registered without having to go through the KY.S.A.T.S Equivalency process.

5. An Association of Registered Music Therapists and a Disciplinary Committee will be formed within 6 months of the passing of the law.

In June 2021, a new president of the Committee on Health Affairs was elected, who suggested that CyMTA should withdraw the first legislative proposal and resubmit the new legislative proposal which was formulated in cooperation with the Legislative Department of the Ministry of Health. The president recommended resubmitting the new legislative proposal as more members of the Committee on Health Affairs would support the legislation since the new legislative proposal would be more complete than the first version, and was vetted by the Ministry of Health and other relevant state services.

In October 2021, the Committee on Health Affairs arranged another meeting regarding the new legislative proposal. All the relevant government bodies and representatives of CyPSA were invited to this session. In this meeting, the representatives of CyPSA raised some objections regarding the definition of music therapy and the way in which music therapists can practise their profession. They mentioned:

Not providing the possibility of autonomous performance of duties. Always upon referral by professionals in the field of mental health and within the framework of the operation of an Interprofessional Group which will also have the responsibility of the wider therapeutic planning and scientific supervision of any interventions. (House of Representatives, 2021).

This statement was considered by CyMTA as extremely wrong since it would hinder the exercise of music therapy as an autonomous health profession. The representatives from CyMTA clarified that music therapists always work within a framework of interprofessional therapeutic planning and that not all cases need a referral from a mental health professional since not all cases of music therapy involve mental illnesses. After this development, the deputy president of the Committee on Health Affairs suggested that a joint meeting between CyMTA and CyPSA should be arranged, so that the dispute could be resolved, and the Committee could proceed to the next stage.

Members of CyMTA proceeded to have a meeting with CyPSA and agreed to add the following provision to the proposed law: "Persons with mental health problems are received for music therapy clinical work only after a referral from a psychiatrist or clinical psychologist" (House of Representatives, 2021). Subsequently, a memorandum was sent by CyMTA to the Committee with the agreed amendments. Despite this agreement, CyPSA submitted a memorandum to the Committee on Health Affairs, reiterating their original position that music therapy cannot function as an autonomous health profession. This act of CyPSA to proceed with a different position while having an initial agreement with CyMTA was considered an irregularity and was ignored by the Committee.

In December 2021, the Committee on Health Affairs arranged a new meeting concerning music therapy legislation and invited all the relevant stakeholders to participate. In this meeting, the modified legislative proposal was read out and some objections were stated. Specifically, the representative of the M.L.S.I. argued that before regulating the music therapy profession in Cyprus, the Committee on Health Affairs should first examine how the music therapy profession is regulated in other European

countries through the database of the European Centre of Parliamentary Research and Documentation (ECPRD). Additionally, the representative from The Legal Services pointed out that a proportionality test should be conducted prior to the voting of the legislation, for the purposes of harmonization with the act of the European Community entitled “Directive” (EU 2018/958) and the Cyprus law [N.. 174(I)/2021] regarding ‘proportionality test for new regulation of professions.’ Also, the representative from the Ministry of Health requested that it should be written in the law that: “People with mental health problems are eligible for music therapy only after a referral from a psychiatrist or a clinical psychologist”. However, the above request was in conflict with the referral procedures which the public schools for Special Education follow, so the representative of the Ministry of Education disagreed. At the end of this meeting, the president of the Committee on Health Affairs stated that, prior to the next meeting, the Ministry of Health must conduct the proportionality test and the research department of the Parliament must carry out an investigation concerning the legislations of music therapy professions in other European countries such as Serbia, the United Kingdom and the U.S.A. Also, the president requested that CyMTA, the Ministry of Health, and the Ministry of Education should have agreed on referral procedures for people with mental health problems (see Republic of Cyprus, 2022a).

The final meeting with the Committee on Health Affairs and all relevant stakeholders was held in March 2022. In that meeting, the research department of the parliament issued its findings about their investigation. According to their research, Music Therapy is regulated by law only in one country of the European Union, Austria. In Latvia and Lithuania, the profession of music therapist has been legally recognized as the profession of art therapist. In the United Kingdom, music therapy is regulated by the Supplementary Medical Professions Act of 1960, which was amended in 1997 to include creative therapists (art therapists, music therapists and drama therapists). Music therapy is one of the 15 Allied Health Professions (AHPs) in the United Kingdom’s National Health System (NHS). Even though music therapy is not a regulated profession, it is taught in many public and private universities and practiced in national health systems across Europe. In some countries, such as Sweden, Estonia, and the Netherlands, music therapists have one or more associations and a code of ethics (see Republic of Cyprus, 2022b). Their findings had a very positive impact and supported the regulation of the profession of music therapy in Cyprus.

Additionally, the representative from the Ministry of Health, read out the report concerning the proportionality test and promoted the legislation concerning the music therapy profession mainly because the legislation will protect individuals who receive music therapy services (see Republic of Cyprus, 2022a). CyMTA also submitted a new memorandum regarding an adjustment in the legislative proposal. According to the memorandum, the Ministry of Health, CyMTA, and the Ministry of Education agreed that the following adjustment should be stated in the law:

People with mental health problems are eligible for music therapy only after a referral from a psychiatrist or a clinical psychologist. This clause is not applicable for the music therapy services which are provided in public schools for Special Education. (Cyprus Law, 2022, p. 859)

After that, the Committee on Health Affairs accepted the adjustments and reviewed all the articles of the legislative proposal. Finally, the president proposed a last meeting, this time between

the members of the Committee only, to check the final legislative proposal prior to the plenary session of the Parliament. The final legislative proposal was formulated by the legal department of the parliament and included all the adjustments which the relevant stakeholders had suggested and were approved.

In April 2022, the members of the Committee on Health Affairs discussed in depth about the whole legislation and concluded that the legislation should be put to a vote in the plenary of the parliament. In May 2022, the “law on the registration of music therapists and other related matters” was unanimously passed in Cyprus by the House of Representatives. Parliamentarians from all political parties supported the legislation and this had a decisive role in the establishment of the music therapy profession in Cyprus.

EPILOGUE

The establishment of regulations that define the practice of music therapy in Cyprus is a great achievement. Cyprus is the second country in the European Union to regulate music therapy as a health profession. The recognition of music therapy as a health profession opens new prospects for the inclusion of music therapy services in the National Health System (GESY), hospitals, mental health facilities, and elderly care homes. Subsequently, music therapy will no longer be considered useful only for children with learning disabilities, but as a therapeutic approach that can work positively for a variety of cases.

The existence of the law safeguards both the music therapist and the patient as it clearly defines the framework in which music therapy professionals acquire and maintain the competence required to provide high quality music therapy services. In other words, it ensures that the provided music therapy services are safe, effective, and patient-centered.

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APPENDIX: COPY OF MEMORANDUM [IN GREEK]⁷

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Υπόμνημα Προς: Κοινοβουλευτική Επιτροπή Υγείας της Βουλής των Αντιπρόσωπων

11 Μαρτίου, 2021

Θέμα: Ο περί Εγγραφής Μουσικοθεραπευτών Νόμος

Ο Σύνδεσμος Μουσικοθεραπείας Κύπρου, ως επίσημο οργανωμένο σύνολο καταρτισμένων μουσικοθεραπευτών στην Κύπρο (Αρ. μητρώου σωματείου 3658), ζητά όπως επανεξεταστεί από την Κοινοβουλευτική Επιτροπή Υγείας η πρόταση του Περί Εγγραφής Μουσικοθεραπευτών Νόμου, η οποία πλέον είναι κατεπείγον σημαντική.

Ως Σύνδεσμος, έχουμε διενεργήσει στο παρελθόν ακόμα δύο συναντήσεις με την Επιτροπή Υγείας της Βουλής, μια τον Οκτώβριο του 2010 και μια τον Ιούνιο του 2013, χωρίς όμως να έχουμε επιτύχει τα επιθυμητά αποτελέσματα. Εκ τότε, έχουν γίνει πολλές αλλαγές και ο αυξημένος αριθμός μουσικοθεραπευτών που εργάζεται στη χώρα μας επιβάλλει τη νομοθετική ρύθμιση του επαγγέλματος, χωρίς να αφήνει πολλά χρονικά περιθώρια αναβολής του.

Η θέσπιση νομοθεσίας του επαγγέλματος των μουσικοθεραπευτών είναι μείζονος σημασίας για τους εξής λόγους:

1. Το νομοθετικό πλαίσιο θα δρα προληπτικά σε πιθανά επικίνδυνα φαινόμενα που μπορούν εύκολα να προκύψουν λόγω της απουσίας του. Για παράδειγμα, παραπλάνηση, εκμετάλλευση και κερδοσκοπία σε βάρος των ασθενών από **μη-Μουσικοθεραπευτές**. Ο Σύνδεσμος έχει δεχτεί πάρα πολλές καταγγελίες σχετικά με άτομα που παρουσιάζουν τους εαυτούς τους ως μουσικοθεραπευτές ενώ δεν είναι και τα οποία εργάζονται σε Ιδρύματα ή άλλες δομές που σχετίζονται με ευάλωτες ομάδες. Δυστυχώς, λόγω της έλλειψης νομοθετικής κατοχύρωσης, ο Σύνδεσμος δεν μπορεί να παρέμβει, έτσι τα άτομα αυτά δρουν ανενόχλητα σε βάρος ευάλωτων ομάδων.
2. Θα διασφαλίζει τη σωστότερη δυνατόν άσκηση του επαγγέλματος του μουσικοθεραπευτή (π.χ. κριτήρια για εγγραφή στο Μητρώο, συνεχιζόμενη επαγγελματική ανάπτυξη) και ως εκ τούτου την ποιοτικότερη δυνατόν παροχή θεραπείας στον ευάλωτο πληθυσμό που καλείται ο μουσικοθεραπευτής να εξυπηρετήσει.
3. Το νομοθετικό πλαίσιο θα είναι το επίσημο σημείο αναφοράς για αμερόληπτη και ακριβή απεικόνιση της φύσης του επαγγέλματος και του επαγγελματία, για εξάλειψη σύγχυσης και αποπροσανατολισμού.

⁷ The current copy is published with the permission of CyMTA.



4. Θα καταστεί επίσημο σημείο εκκίνησης για μια σωστή πορεία και ανέλιξη του επαγγέλματος, όπως και συμπερίληψής του στο ΓΕΣΥ, πράγμα που έχει ήδη γίνει για συναφή επαγγέλματα υγείας.
5. Οι μουσικοθεραπευτές χρήζουν ίσης μεταχείρισης με τους υπόλοιπους επαγγελματίες υγείας αναφορικά με τη διασφάλιση των επαγγελματικών τους καθηκόντων, όπως και των εργασιακών τους δικαιωμάτων.
6. Τέλος, πρέπει να σημειωθεί ότι το επάγγελμα της μουσικοθεραπείας ήδη ασκείται στην Κύπρο και ο ρυθμός ζήτησης και παροχής του αυξάνεται συνεχώς τα τελευταία χρόνια. Οι μουσικοθεραπευτές εργοδοτούνται τόσο από το Υπουργείο Υγείας, στις Υπηρεσίες Ψυχικής Υγείας (με αγορά υπηρεσιών), όσο και από το Υπουργείο Παιδείας, Πολιτισμού, Αθλητισμού και Νεολαίας στα Ειδικά Σχολεία. Η χρησιμότητα της μουσικοθεραπείας αποδεικνύεται από την αύξηση των μουσικοθεραπευτών στα Ειδικά Σχολεία. Από το 2017, το Υπουργείο Παιδείας, Πολιτισμού, Αθλητισμού και Νεολαίας διόρισε ακόμα δέκα μουσικοθεραπευτές, που σύμφωνα με τα στοιχεία διορισμών 2019-2020, το ποσοστό των έκτακτων έφτασε το 63,15%, το πιο ψηλό ποσοστό σε σύγκριση με τις υπόλοιπες ειδικότητες. Αυτό αδιαμφισβήτητα οφείλεται, σε ένα μεγάλο βαθμό, στην αποδοχή της συμβολής και αποτελεσματικότητας που έχει επιδείξει ο κλάδος. Έτσι, η θέσπιση νομοθεσίας γίνεται τάχιστα πιο αναγκαία για όλους τους πιο πάνω λόγους.

Αξίζει να σημειωθεί πως ο Σύνδεσμος έχει μελετήσει εκτενέστερα το θέμα των προσόντων για εγγραφή στο μητρώο (άρθρο 8 στην πρόταση), μετά από εκδήλωση διαφόρων απόψεων και προβληματισμών, κατά τη διάρκεια των προηγούμενων συνεδριών του 2010 και 2013. Οι προβληματισμοί επικεντρώνονταν κυρίως στο γεγονός ότι προτείνεται αναγνώριση Μεταπτυχιακού-Μαστερ στη Μουσικοθεραπεία, ως επαρκές προσόν για εγγραφή στο μητρώο. Ο Σύνδεσμος, από τότε έχει κάνει αρκετές ενέργειες ώστε να διασφαλίσει πως η κατάρτιση των μουσικοθεραπευτών με μαστερ από αναγνωρισμένα πανεπιστήμια του εξωτερικού είναι επαρκές προσόν:

1. Μετά από μια σειρά βημάτων του Συνδέσμου με εκπροσώπους του Υπουργείου Παιδείας, Πολιτισμού, Αθλητισμού και Νεολαίας και του ΚΥΣΑΤΣ, καταφέραμε να γίνεται συνεκτίμηση του μεταπτυχιακού τίτλου επιπέδου Master στη Μουσικοθεραπεία και του πρώτου πτυχίου των υποψηφίων και να δίνεται τίτλος ισότιμος και αντίστοιχος προς Πτυχίο πανεπιστημιακού επιπέδου στον κλάδο/ειδίκευση της Μουσικοθεραπείας.
2. Επίσης, πρέπει να τονίσουμε πως στις πλείστες περιπτώσεις όπου οι υποψήφιοι ήταν κάτοχοι μεταπτυχιακού στη Μουσικοθεραπεία, κατά τη συνεκτίμηση δεν υπολείπονταν μαθήματα σε σχέση με το πρότυπο πρόγραμμα σπουδών Μουσικοθεραπείας, όπως αυτό καθορίζεται από το ΚΥΣΑΤΣ.



3. Το ΚΥΣΑΤΣ μετά από συναντήσεις που κάναμε με την επιτροπή του, διόρισε, ως ανεξάρτητους κριτές, δυο ακαδημαϊκούς, εγνωσμένου κύρους, οι οποίοι είναι καθηγητές σε αναγνωρισμένα πανεπιστήμια του εξωτερικού, στον κλάδο της Μουσικοθεραπείας.

Επιπροσθέτως, θα πρέπει να τονίσουμε πως τα αναγνωρισμένα προγράμματα μουσικοθεραπείας, στις περισσότερες ευρωπαϊκές χώρες και ιδιαίτερα του Ηνωμένου Βασιλείου (από πού οι περισσότεροι Κύπριοι Μουσικοθεραπευτές είναι απόφοιτοι), είναι σε **Μεταπτυχιακό-Μάστερ** επίπεδο. Αυτά τα μεταπτυχιακά είναι σχεδιασμένα ώστε να προετοιμάσουν τον μουσικοθεραπευτή να μπορεί να ανταπεξέλθει σε ένα απαιτητικό τομέα, όπως είναι ο ευρύτερος τομέας της υγείας και να προσφέρει την καλύτερη ποιότητα υπηρεσιών. Περιλαμβάνουν κλινική εμπειρία και συνεχή εποπτεία.

Το Ηνωμένο Βασίλειο, είναι μία από τις τρεις Ευρωπαϊκές χώρες, μαζί με την Αυστρία και τη Λετονία, όπου το επάγγελμα του μουσικοθεραπευτή διέπεται από ανάλογη νομοθεσία από το 1996. Όσον αφορά στις σπουδές και στην διαδικασία αναγνώρισης της μουσικοθεραπείας στο Ηνωμένο Βασίλειο, έχει γίνει μια εκτενής αξιολόγηση των Μουσικοθεραπευτών που έπρεπε για αρκετό καιρό, γι' αυτόν τον λόγο, να συνεργαστούν με το Υπουργείο Υγείας (Department of Health-DoH). Αφού συλλέχθηκαν αρκετά στοιχεία για την επίδραση και αποτελεσματικότητα της συνεισφοράς της μουσικοθεραπείας ως επάγγελμα υγείας, τότε οι μουσικοθεραπευτές μπορούσαν να υποβάλουν αίτηση στο τότε Συμβούλιο Επαγγελματιών Υγείας (Health Professions Council-HPC, το οποίο ενεργεί ως Συμβούλιο Εγγραφής 20 περίπου Επαγγελματιών Υγείας). Εφόσον η αίτηση γινόταν αποδεκτή, τότε θα μπορούσε να περάσει προς κοινοβουλευτική ψήφιση και οι μουσικοθεραπευτές σε επαγγελματική κατοχύρωση (από τα πρακτικά της Γενικής Συνέλευσης της Ευρωπαϊκής Συνομοσπονδίας Μουσικοθεραπείας (EMTC) στο Ταλλίν τον Ιούνιο του 2012 – αναφορά της Τέσσα Ουότσον, εκπροσώπου Ηνωμένου Βασιλείου στο θέμα αναγνώριση/εγγραφή).

Επιπλέον, είναι ευρέως αποδεκτό πως το εκπαιδευτικό και το επαγγελματικό επίπεδο στο Ηνωμένο Βασίλειο είναι από τα πλέον αξιόπιστα στην Ευρώπη. Αναφερόμαστε στο παράδειγμα του Ηνωμένου Βασιλείου γιατί οφείλουμε να λάβουμε σοβαρά υπόψη τις τάσεις χωρών όπου το επάγγελμα είναι ήδη εδραιωμένο και κατοχυρωμένο, ιδιαίτερα λόγω του ότι δεν υπάρχει ακόμη αναγνωρισμένο πανεπιστημιακό πρόγραμμα στον τομέα της μουσικοθεραπείας στην Κύπρο, αλλά ούτε και στην Ελλάδα, για να υπάρξει έγκυρο μέτρο σύγκρισης.

Εν κατακλείδι και λαμβάνοντας υπόψη όλα τα παραπάνω, πιστεύουμε ότι είναι σημαντικό να υπάρξει, σε αυτό το εξελικτικό στάδιο, ανάλογη νομοθεσία που να ρυθμίζει το επάγγελμα όπως και Συμβούλιο Εγγραφής που θα πιστοποιεί την κατάρτιση του μουσικοθεραπευτή και θα κατευθύνει προς τακτική συνεχιζόμενη επαγγελματική ανάπτυξη, για την πιο ποιοτική παροχή θεραπειών. Με αυτόν τον τρόπο θα προστατεύεται στο μέγιστο, οποιοδήποτε άτομο παραπέμπεται, χρειάζεται, επιζητεί και λαμβάνει τις υπηρεσίες μουσικοθεραπείας, όπως και θα διασφαλίζεται και το δικαίωμα που έχουν οι μουσικοθεραπευτές να είναι αναγνωρισμένο και



κατοχυρωμένο επάγγελμα υγείας, ακολουθώντας τα πρότυπα εργασίας που επικρατούν στις υπόλοιπες Ευρωπαϊκές και ανεπτυγμένες χώρες.

Εκ Μέρους του Συνδέσμου Μουσικοθεραπείας Κύπρου

Αντωνία Πλυσή
(Πρόεδρος)

Ελληνική περίληψη | Greek abstract

Η πορεία της νομοθετικής ρύθμισης του επαγγέλματος της μουσικοθεραπείας στην Κύπρο

Αντωνία Πλυσή | Παναγιώτα Καπνίση

ΠΕΡΙΛΗΨΗ

Στις 5 Μαΐου 2022, ψηφίστηκε ομόφωνα από τη Βουλή των Αντιπροσώπων στην Κύπρο, ο νόμος που προβλέπει για την εγγραφή μουσικοθεραπευτών και για άλλα συναφή θέματα [N.68(1)2022]. Η παρούσα αναφορά περιγράφει αναλυτικά τη διαδικασία που ακολουθήθηκε από τον Σύνδεσμο Μουσικοθεραπείας Κύπρου (ΣΥ.ΜΟΥ.Κ.) προκειμένου να επιτευχθεί η νομοθετική ρύθμιση του μουσικοθεραπευτικού επαγγέλματος. Πριν αναλύσουμε σε βάθος τη διαδικασία, παρουσιάζουμε μια σύντομη εισαγωγή στην ιστορία της Κύπρου, για να διευκρινίσουμε την ιδιαίτερη πολιτική συνθήκη που επικρατεί στη χώρα. Έπειτα, κάνουμε μια ιστορική αναδρομή στην εξέλιξη της μουσικοθεραπείας και του μουσικοθεραπευτικού επαγγέλματος στην Κύπρο και εν κατακλείδι περιγράφουμε το κυπριακό συνταγματικό πλαίσιο, καθώς η νομοθετική κατοχύρωση του μουσικοθεραπευτικού επαγγέλματος στην Κύπρο επιτεύχθηκε κυρίως μέσω συνταγματικών διαδικασιών.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

Κύπρος, νόμος μουσικοθεραπείας, νομοθετική κατοχύρωση, επάγγελμα υγείας, νομοθετική ρύθμιση

ΑΝΑΦΟΡΑ

Η πορεία της νομοθετικής ρύθμισης του επαγγέλματος της μουσικοθεραπείας στην Κύπρο

Αντωνία Πλυσή

Ανεξάρτητη επιστήμονας, Κύπρος

Παναγιώτα Καπνίση

Ανεξάρτητη επιστήμονας, Κύπρος

ΠΕΡΙΛΗΨΗ

Στις 5 Μαΐου 2022, ψηφίστηκε ομόφωνα από τη Βουλή των Αντιπροσώπων στην Κύπρο, ο νόμος που προβλέπει για την εγγραφή μουσικοθεραπευτών και για άλλα συναφή θέματα [N.68(1)2022]. Η παρούσα αναφορά περιγράφει αναλυτικά τη διαδικασία που ακολουθήθηκε από τον Σύνδεσμο Μουσικοθεραπείας Κύπρου (ΣΥ.ΜΟΥ.Κ.) προκειμένου να επιτευχθεί η νομοθετική ρύθμιση του μουσικοθεραπευτικού επαγγέλματος. Πριν αναλύσουμε σε βάθος τη διαδικασία, παρουσιάζουμε μια σύντομη εισαγωγή στην ιστορία της Κύπρου, για να διευκρινίσουμε την ιδιαίτερη πολιτική συνθήκη που επικρατεί στη χώρα. Έπειτα, κάνουμε μια ιστορική αναδρομή στην εξέλιξη της μουσικοθεραπείας και του μουσικοθεραπευτικού επαγγέλματος στην Κύπρο και εν κατακλείδι περιγράφουμε το κυπριακό συνταγματικό πλαίσιο, καθώς η νομοθετική κατοχύρωση του μουσικοθεραπευτικού επαγγέλματος στην Κύπρο επιτεύχθηκε κυρίως μέσω συνταγματικών διαδικασιών.

ΒΙΟΓΡΑΦΙΕΣ ΣΥΓΓΡΑΦΕΩΝ

Η **Αντωνία Πλυσή** είναι μουσικοθεραπεύτρια, μουσικολόγος και καθηγήτρια κλασικής κιθάρας που ζει και εργάζεται στην Κύπρο. Η Αντωνία πήρε το πρώτο της πτυχίο στις Μουσικές Σπουδές από το Εθνικό και Καποδιστριακό Πανεπιστήμιο Αθηνών και ακολούθως σπούδασε Μουσικοθεραπεία σε μεταπτυχιακό επίπεδο στο Anglia Ruskin University, Ηνωμένο Βασίλειο, με υποτροφία από την Κυπριακή Δημοκρατία λόγω άριστης επίδοσης. Εργάζεται ως μουσικοθεραπεύτρια στα κρατικά σχολεία ειδικής αγωγής και εκπαίδευσης της Κύπρου από το 2018 και είναι πρόεδρος του ΣΥ.ΜΟΥ.Κ. από το 2016. Ως πρόεδρος του ΣΥ.ΜΟΥ.Κ. δραστηριοποιήθηκε κυρίως στην αναγνώριση της μουσικοθεραπείας ως επάγγελμα υγείας στην Κύπρο και στην επίτευξη μιας κρατικής νομοθεσίας που να διέπει την εγγραφή των μουσικοθεραπευτών. [plysi.antonina@gmail.com] Η **Παναγιώτα Καπνίση** είναι μουσικοθεραπεύτρια και δασκάλα τραγουδιού που ζει και εργάζεται στην Κύπρο από το 2014. Αποφοίτησε από το Πανεπιστήμιο του Στρασβούργου με πτυχίο και μεταπτυχιακό στη Μουσικολογία και τη Μουσική με γαλλική υποτροφία. Στη συνέχεια, ολοκλήρωσε το μεταπτυχιακό της στη Μουσικοθεραπεία στο Πανεπιστήμιο του Roehampton, όπου παράλληλα πήρε υποτροφία για να συνεχίσει τις σπουδές της στην όπερα κατακτώντας δίπλωμα στο κλασικό τραγούδι από το Trinity College of London. Η Παναγιώτα διαθέτει ένα ευρύ φάσμα επαγγελματικής εμπειρίας ως μουσικοθεραπεύτρια, που περιλαμβάνει εργασία στους εξής τομείς: παιδιά και ενήλικες με μαθησιακές και πολλαπλές αναπηρίες, ψυχική υγεία, αποκατάσταση και κέντρα ευημερίας. Η Παναγιώτα είναι μέλος του συμβουλίου του ΣΥ.ΜΟΥ.Κ. από το 2019 και έχει εργαστεί ενεργά στη διαδικασία για τη νομοθετική κατοχύρωση του μουσικοθεραπευτικού επαγγέλματος στην Κύπρο. [panagiota.kapnisi@gmail.com]

ΚΥΠΡΟΣ: ΜΙΑ ΣΥΝΤΟΜΗ ΙΣΤΟΡΙΚΗ ΑΝΑΔΡΟΜΗ

Η Κύπρος, επίσημα αποκαλούμενη Κυπριακή Δημοκρατία, είναι μια νησιωτική χώρα στην ανατολική Μεσόγειο. Είναι το τρίτο μεγαλύτερο νησί της Μεσογείου και βρίσκεται ανατολικά της Ελλάδας,

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

Κύπρος,
νόμος
μουσικοθεραπείας,
νομοθετική
κατοχύρωση,
επάγγελμα υγείας,
νομοθετική ρύθμιση

Ιστορία δημοσίευσης:
Υποβολή 9 Δεκ. 2022
Αποδοχή 18 Μαρ. 2023
Δημοσίευση 13 Οκτ. 2023

νότια της Τουρκίας, δυτικά της Συρίας και βόρεια της Αιγύπτου (WorldAtlas, 2018). Η Κύπρος λόγω της σημαντικής γεωπολιτικής θέσης της, υπήρξε πόλος έλξης για πολλές αποικιακές και κατακτητικές δυνάμεις της Ανατολικής Μεσογείου κατά το πέρασμα των χρόνων (Campbell, 2003). Η τελευταία αποικιακή δύναμη που κατέλαβε το νησί ήταν η Βρετανική από το 1878 μέχρι το 1960.

Το έτος 1960 ήταν ορόσημο στη μακρόχρονη ιστορία της Κύπρου, μιας και για πρώτη φορά η Κύπρος ανακηρύσσεται ανεξάρτητο και κυρίαρχο κράτος για όλους τους κατοίκους του νησιού, όπου κατοικούσαν περίπου 78% Ελληνοκύπριοι, 18% Τουρκοκύπριοι, 1% Μαρωνίτες, Αρμένιοι και Λατίνοι και 3% άλλοι. Παρά την ανεξαρτησία της Κύπρου, διαφωνίες στο σύνταγμα του 1960 οδήγησαν σε επεισόδια μεταξύ Τουρκοκυπριακών και Ελληνοκυπριακών κοινοτήτων και τον αποκλεισμό των Τουρκοκυπρίων σε θύλακες το 1963 (Countrystudies.us, 1963).

Τον Ιούλιο του 1974, ένα πραξικόπημα υποστηριζόμενο από τη στρατιωτική χούντα στην εξουσία στην Ελλάδα ανέτρεψε τη δημοκρατικά εκλεγμένη κυβέρνηση, αναγκάζοντας τον Κύπριο Πρόεδρο να φύγει από τη χώρα (Mallinson, 2005). Αυτή η ενέργεια έγινε η αφορμή για την τουρκική εισβολή στην Κύπρο στις 20 Ιουλίου, η οποία οδήγησε στην κατάληψη του σημερινού εδάφους της κατεχόμενης Κύπρου (βόρειο τμήμα). Η Κυπριακή Δημοκρατία χωρίζεται εκ των πραγμάτων σε δύο βασικά μέρη: την περιοχή υπό τον ουσιαστικό έλεγχο της Δημοκρατίας, που βρίσκεται στα νότια και δυτικά και περιλαμβάνει περίπου το 58% της έκτασης του νησιού, και τη βόρεια (την κατεχόμενη), που διοικείται από την αυτοαποκαλούμενη Τουρκική Δημοκρατία της Βόρειας Κύπρου, που καλύπτει περίπου το 37% της έκτασης του νησιού. Ένα άλλο σχεδόν 5% της έκτασης του νησιού καταλαμβάνεται από τη ζώνη ασφαλείας του ΟΗΕ (Πράσινη Γραμμή) και από το Ηνωμένο Βασίλειο, το οποίο διατηρεί τις περιοχές κυρίαρχων βάσεων Ακρωτηρίου και Δεκέλειας (McArthur και συν., 2018).

Μετά από μια μακρά πολυτάραχη πολιτική πορεία, η Κύπρος εντάχθηκε στην Ευρωπαϊκή Ένωση την 1^η Μαΐου 2004. Σύμφωνα με τους όρους της ένταξής της, ολόκληρο το νησί θεωρείται τεχνικά μέλος της Ευρωπαϊκής Ένωσης, παρά τη συνεχιζόμενη διαίρεση του και το γεγονός ότι η κυβέρνηση της Δημοκρατίας δεν έχει επιρροή στο βόρειο τμήμα του νησιού (Ker-Lindsay και συν., 2011).

Βάσει αυτής της σύντομης ιστορικής αναδρομής, διευκρινίζουμε πως στην παρούσα αναφορά, όταν αναφερόμαστε στην Κύπρο, εννοούμε μόνο το επίσημα αναγνωρισμένο νότιο τμήμα. Κατ' επέκταση, αναλύουμε παρακάτω τη διαδικασία της νομοθετικής ρύθμισης του μουσικοθεραπευτικού επαγγέλματος όπως αυτό ασκείται στις περιοχές που ελέγχονται από την επίσημη κυβέρνηση της Κυπριακής Δημοκρατίας.

Η ΜΟΥΣΙΚΟΘΕΡΑΠΕΙΑ ΣΤΗΝ ΚΥΠΡΟ: ΑΠΑΡΧΕΣ ΚΑΙ ΕΞΕΛΙΞΗ

Το 1987, η Ανθή Αγρότου, η πρώτη Κύπρια μουσικοθεραπεύτρια, επέστρεψε από το Ηνωμένο Βασίλειο, όπου είχε σπουδάσει μουσικοθεραπεία και δημιούργησε την πρώτη θέση εργασίας στο τομέα της μουσικοθεραπείας στη «Νέα Ελεούσα», ένα ίδρυμα για άτομα με σοβαρές μαθησιακές δυσκολίες. Το γεγονός αυτό ήταν η απαρχή της μουσικοθεραπείας στην Κύπρο.

Έπειτα, το 1999, με την εφαρμογή του νέου νόμου «περί Αγωγής και Εκπαίδευσης Παιδιών με Ειδικές Ανάγκες» [Ν.113(1)/99], το Υπουργείο Παιδείας και Πολιτισμού προσέλαβε για πρώτη φορά μουσικοθεραπευτές στα κρατικά σχολεία ειδικής αγωγής και εκπαίδευσης. Σημαντικό ρόλο στη συμπερίληψη της μουσικοθεραπείας στα θεραπευτικά προγράμματα διαδραμάτισε το γεγονός πως η Αγρότου υπήρξε μέλος της «Ειδικής Επιτροπής για Μελέτη Τρόπων Παροχής Βοήθειας στα Παιδιά με Ειδικές Ανάγκες», η οποία διορίστηκε από το Υπουργείο Παιδείας και Πολιτισμού (Υπουργείο Παιδείας και Πολιτισμού, 1992). Η έκθεση της επιτροπής που παραδόθηκε το φθινόπωρο του 1992 αποτέλεσε τη βάση του Νόμου 113(1)/99, ο οποίος ενσωμάτωνε πλέον τα περισσότερα παιδιά με μαθησιακές δυσκολίες στα τυπικά σχολεία (Agrotou, 2008). Η συμπερίληψη της μουσικοθεραπείας στο θεραπευτικό πρόγραμμα των κρατικών σχολείων ειδικής αγωγής και εκπαίδευσης αποτέλεσε ένα πολύ σημαντικό βήμα, καθώς αντιπροσώπευε την πρώτη ουσιαστική αναγνώριση του μουσικοθεραπευτικού επαγγέλματος στην Κύπρο.

Έκτοτε δημιουργήθηκαν θέσεις εργασίας και σε άλλα πλαίσια, εκτός από τα ειδικά σχολεία, όπως σε ιδρύματα για παιδιά και ενήλικες με σοβαρή μαθησιακή αναπηρία, σε ψυχιατρικές μονάδες και σε οίκους ευγηρίας. Ωστόσο, η πλειοψηφία των μουσικοθεραπευτών στην Κύπρο εργάζεται κυρίως με παιδιά και εφήβους με μαθησιακές δυσκολίες στα κρατικά σχολεία ειδικής αγωγής και εκπαίδευσης ή ως αυτοαπασχολούμενοι μουσικοθεραπευτές στον ιδιωτικό τομέα.

Σήμερα, ο αριθμός των καταρτισμένων μουσικοθεραπευτών στην Κύπρο έχει φτάσει τους 35. Όλοι είναι απόφοιτοι εκπαιδευτικών προγραμμάτων (επιπέδου πτυχίου ή μεταπτυχιακού) του εξωτερικού όπως ΗΠΑ, Ηνωμένο Βασίλειο, Γερμανία, Φινλανδία και Αυστρία, καθώς δεν υπάρχει κανένα εγχώριο πρόγραμμα εκπαίδευσης στη μουσικοθεραπεία. Αξίζει να σημειωθεί ότι από το 2008 μέχρι το 2016, οι μουσικοθεραπευτές που ήταν απόφοιτοι μεταπτυχιακών προγραμμάτων και όχι πτυχίων αποκλείστηκαν από τα σχέδια υπηρεσίας του Υπουργείου Παιδείας και Πολιτισμού και δεν μπορούσαν να εργαστούν στα κρατικά σχολεία ειδικής αγωγής και εκπαίδευσης.

Αυτή η ποικιλομορφία στο εκπαιδευτικό υπόβαθρο των μουσικοθεραπευτών στην Κύπρο και ο αποκλεισμός των μουσικοθεραπευτών με μεταπτυχιακό από τα σχέδια υπηρεσίας του Υπουργείου Παιδείας και Πολιτισμού έκανε πιο επιτακτική την ύπαρξη ενός επίσημου νομοθετικού πλαισίου ρύθμισης του επαγγέλματος του μουσικοθεραπευτή. Αυτό οδήγησε στην ίδρυση του ΣΥ.ΜΟΥ.Κ. το 2010, που ανέλαβε τον ρόλο ενός επίσημου επαγγελματικού φορέα που προωθεί ζητήματα γύρω από τη μουσικοθεραπεία. Άλλα σημαντικά ορόσημα στην πορεία της μουσικοθεραπείας στην Κύπρο ήταν το 2011, όταν ο ΣΥ.ΜΟΥ.Κ. έγινε μέλος της Ευρωπαϊκής Συνομοσπονδίας Μουσικοθεραπείας (European Music Therapy Confederation, EMTC) και το 2020, όταν εντάχθηκε στην Παγκόσμια Ομοσπονδία Μουσικοθεραπείας (World Federation of Music Therapy, WFMT).¹

ΤΟ ΣΥΝΤΑΓΜΑΤΙΚΟ ΠΛΑΙΣΙΟ ΤΗΣ ΚΥΠΡΟΥ

Η Κυπριακή Δημοκρατία λειτουργεί με προεδρικό σύστημα διακυβέρνησης, όπου ο Πρόεδρος είναι ταυτόχρονα αρχηγός του κράτους και της κυβέρνησης, με την εκτελεστική εξουσία να ασκείται από την κυβέρνηση. Η νομοθετική εξουσία ανήκει τόσο στην κυβέρνηση όσο και στο κοινοβούλιο (Βουλή

¹ Σύνδεσμος Μουσικοθεραπευτών Κύπρου: www.cymta.org

των αντιπροσώπων) και η δικαστική εξουσία είναι ανεξάρτητη από την εκτελεστική και τη νομοθετική.

Κατά συνέπεια, η Βουλή των Αντιπροσώπων είναι το κατ' εξοχήν νομοθετικό όργανο και η νομοθετική της λειτουργία συνίσταται στη θέσπιση, τροποποίηση ή κατάργηση κανόνων δικαίου. Οι προτάσεις νόμου κατατίθενται στη Βουλή με τη μορφή νομοσχεδίων από τους βουλευτές. Κάθε σχέδιο νόμου που υποβάλλεται στη Βουλή πρέπει να συνοδεύεται από μια αιτιολογική έκθεση η οποία περιγράφει τους λόγους που επιβάλλουν την έγκριση ή τροποποίηση ή κατάργηση της σχετικής νομοθεσίας.

Για την πιο εύρυθμη διεκπεραίωση των κοινοβουλευτικών εργασιών, το Σύνταγμα και ο Κανονισμός της Βουλής προβλέπουν τη σύσταση και τη λειτουργία επιτροπών. Η σύνθεσή τους αποφασίζεται από την Επιτροπή Επιλογής και όλα τα πολιτικά κόμματα εκπροσωπούνται δεόντως. Οι κοινοβουλευτικές επιτροπές χωρίζονται σε μόνιμες, που αντιστοιχούν στα αντίστοιχα Υπουργεία και σε άλλες προσωρινές, *ad hoc* (επί τούτου) ή ειδικές. Στην περίπτωση των μουσικοθεραπευτών, η διερεύνηση του θέματος της νομοθετικής ρύθμισης του επαγγέλματος ανατέθηκε στην Επιτροπή Υγείας.

Η ΠΟΡΕΙΑ ΠΡΟΣ ΤΗ ΝΟΜΟΘΕΤΙΚΗ ΚΑΤΟΧΥΡΩΣΗ ΤΟΥ ΕΠΑΓΓΕΛΜΑΤΟΣ ΤΟΥ ΜΟΥΣΙΚΟΘΕΡΑΠΕΥΤΗ²

Οι προσπάθειες για τη νομοθετική ρύθμιση του επαγγέλματος του μουσικοθεραπευτή ξεκίνησαν από το 2010, από την λεγόμενη «Ομάδα πρωτοβουλίας για τη Μουσικοθεραπεία».³ Το πρώτο βήμα αυτής της προσπάθειας ήταν η διαμόρφωση μιας νομοθετικής πρότασης σε συνεργασία με δικηγόρο. Ακολούθως, η νομοθετική πρόταση κατατέθηκε στην Επιτροπή Υγείας της Βουλής με την απαραίτητη αιτιολογική έκθεση, η οποία επεξηγούσε αναλυτικά την αναγκαιότητα θέσπισης νομοθεσίας για το επάγγελμα του μουσικοθεραπευτή. Το 2013, ο ΣΥ.ΜΟΥ.Κ. υπέβαλε ξανά τροποποιημένη νομοθετική πρόταση στην Επιτροπή Υγείας, ωστόσο, όλες οι διαπραγματεύσεις σχετικά με τη νομοθετική ρύθμιση απέβησαν άκαρπες. Η κύρια αιτία για την οποία δεν προχώρησε η διαδικασία ήταν γιατί ο Παγκύπριος Σύλλογος Ψυχολόγων (ΠΑ.ΣΥ.ΨΥ.) εναντιώθηκε υποστηρίζοντας πως οι μουσικοθεραπευτές δεν είναι καταρτισμένοι επαρκώς για να αναλαμβάνουν περιστατικά με θέματα ψυχικής υγείας. Στήριξαν το επιχειρήμα τους στο γεγονός πως οι περισσότεροι μουσικοθεραπευτές ήταν απόφοιτοι διετών μεταπτυχιακών προγραμμάτων και όχι πτυχίων, αγνοώντας το γεγονός πως σχεδόν σε ολόκληρη την Ευρώπη η μουσικοθεραπεία διδασκόταν κατά κύριο λόγο υπό αυτή τη μορφή.

Το 2020, ο ΣΥ.ΜΟΥ.Κ. εργάστηκε πιο εντατικά πάνω στο θέμα της νομοθετικής ρύθμισης του επαγγέλματος, μιας και δεν υπήρχαν πλέον περιθώρια αναβολής του. Μερικοί από τους λόγους που επέβαλαν άμεσα την ύπαρξη νομοθεσίας ήταν: 1) ο αυξανόμενος αριθμός μουσικοθεραπευτών στη χώρα, 2) η αύξηση της ζήτησης για υπηρεσίες μουσικοθεραπείας, 3) οι πολλές καταγγελίες σχετικά με άτομα που παρουσίαζαν τους εαυτούς τους ως μουσικοθεραπευτές, ενώ δεν ήταν, και τα οποία

² Τα γεγονότα επιβεβαιώνονται από την έκθεση της Κοινοβουλευτικής Επιτροπής Υγείας για την πρόταση νόμου «Ο περί Εγγραφής Μουσικοθεραπευτών και για Άλλα Συναφή Θέματα Νόμος του 2021» (βλ. Κυπριακή Δημοκρατία, 2022α).

³ Τα άτομα αυτής της ομάδας αργότερα δημιούργησαν τον ΣΥ.ΜΟΥ.Κ..

εργάζονταν σε ιδρύματα ή άλλες δομές που σχετίζονται με ευάλωτες ομάδες. Δυστυχώς, λόγω της έλλειψης νομοθετικής κατοχύρωσης, ο Σύνδεσμος δεν μπορούσε να παρέμβει, έτσι τα άτομα αυτά δρούσαν ανενόχλητα, και 4) η συμπερίληψη της μουσικοθεραπείας στο Γενικό Σύστημα Υγείας (ΓΕΣΥ), πράγμα που είχε ήδη γίνει για συναφή επαγγέλματα υγείας (βλ. Παράρτημα).

Από το Φεβρουάριο του 2020 μέχρι και το Μάρτιο του 2021 τα μέλη του Κεντρικού Συμβουλίου του ΣΥ.ΜΟΥ.Κ. προσέγγιζαν βουλευτές από διαφορετικές πολιτικές παρατάξεις, οι οποίοι ήταν μέλη της Επιτροπής Υγείας, προκειμένου να τους παροτρύνουν να προωθήσουν τη νομοθετική πρόταση. Οι συνεχόμενες πιέσεις προς τους βουλευτές τελικά απέδωσαν και το Μάρτιο του 2021, η Επιτροπή Υγείας της Βουλής διοργάνωσε την πρώτη επίσημη συνεδρίαση σχετικά με τον «Περί εγγραφής Μουσικοθεραπευτών και άλλα συναφή θέματα νόμο». Η Επιτροπή Υγείας κάλεσε τους σχετικούς κρατικούς φορείς όπως μεταξύ άλλων το Υπουργείο Υγείας Κύπρου, το Κυπριακό Συμβούλιο Αναγνώρισης Τίτλων Σπουδών (ΚΥ.Σ.Α.Τ.Σ.)⁴, το Υπουργείο Παιδείας, Αθλητισμού και Νεολαίας Κύπρου (Υ.Π.Π.Α.Ν.), το Υπουργείο Εργασίας και Κοινωνικών Ασφαλίσεων (Υ.Ε.Κ.Α.), τη Νομική Υπηρεσία της Δημοκρατίας και τον ΠΑ.ΣΥ.ΨΥ., να συμμετάσχουν και να τοποθετηθούν επί του θέματος.

Στην πρώτη συνάντηση, όλοι οι φορείς εξέφρασαν τις απόψεις και τις ανησυχίες τους. Αρχικά, ο εκπρόσωπος του Υ.Π.Π.Α.Ν., υποστήριξε την αναγκαιότητα θέσπισης νομοθεσίας δηλώνοντας ότι: «Οι μουσικοθεραπευτές εργάζονται εδώ και 20 χρόνια στα κρατικά σχολεία ειδικής αγωγής και εκπαίδευσης και είναι ευρέως αποδεκτό ότι έχουν διαδραματίσει σημαντικό ρόλο στη θεραπευτική διαδικασία των μαθητών με μαθησιακές δυσκολίες» (Βουλή, 2021). Έπειτα, το ΚΥ.Σ.Α.Τ.Σ. επεσήμανε ότι προκειμένου να αποδεχτεί τη νομοθετική πρόταση, αυτή θα πρέπει να περιλαμβάνει τα ίδια κριτήρια αναφορικά με την αναγνώριση των τίτλων σπουδών των υποψηφίων με αυτά που θέτει το ΚΥ.Σ.Α.Τ.Σ. Επιπλέον ο ΠΑ.ΣΥ.ΨΥ. εξέφρασε ορισμένες ανησυχίες κυρίως για τη διαδικασία παραπομπής που πρέπει να ακολουθείται προκειμένου ένα άτομο να λάβει υπηρεσίες μουσικοθεραπείας και τη διατύπωση του ορισμού της μουσικοθεραπείας. Επιπρόσθετα, ο ΣΥ.ΜΟΥ.Κ. υπέβαλε υπόμνημα (βλ. Παράρτημα) συνοδευόμενο από επιστολές υποστήριξης από γιατρούς, συναφή συλλόγους και θεραπευτικά πλαίσια όπου παρέχονταν υπηρεσίες μουσικοθεραπείας. Τέλος, ο πρόεδρος της Επιτροπής Υγείας ανακοίνωσε ότι η ρύθμιση του επαγγέλματος του μουσικοθεραπευτή φαίνεται να είναι σημαντική και ανέθεσε τη διαμόρφωση του νόμου στο Νομοθετικό Τμήμα του Υπουργείου Υγείας.

Το επόμενο σημαντικό βήμα στη διαδικασία της νομοθετικής κατοχύρωσης ήταν η διαμόρφωση του νόμου σε συνεργασία με το Νομοθετικό Τμήμα του Υπουργείου Υγείας. Μέλη του Κεντρικού Συμβουλίου του ΣΥ.ΜΟΥ.Κ. συνεργάστηκαν στενά με τα αρμόδια στελέχη του Υπουργείου Υγείας και τροποποίησαν την αρχική νομοθετική πρόταση ακολουθώντας τα πρότυπα των νόμων για άλλα επαγγέλματα υγείας. Κρίσιμα σημεία στη διαδικασία διαμόρφωσης του νόμου ήταν ο καθορισμός των ακαδημαϊκών προσόντων που πρέπει να κατέχει ένας μουσικοθεραπευτής για να εγγραφεί, ο ορισμός της μουσικοθεραπείας και το Συμβούλιο Εγγραφής.

⁴ Το ΚΥ.Σ.Α.Τ.Σ. είναι το αρμόδιο σώμα της Κυπριακής Δημοκρατίας για την ακαδημαϊκή αναγνώριση τίτλων σπουδών που απονέμονται από αναγνωρισμένα ιδρύματα ανώτερης ή ανώτατης εκπαίδευσης ή από αξιολογημένα/πιστοποιημένα προγράμματα σπουδών.

Η επίτευξη συμφωνίας σχετικά με τα ακαδημαϊκά προσόντα ήταν πολύ δύσκολη, καθώς οι μουσικοθεραπευτές στην Κύπρο προέρχονται από διαφορετικά εκπαιδευτικά προγράμματα, με διαφορετικά πρότυπα. Μετά από έρευνα και ανάλυση των πλείστων εκπαιδευτικών προγραμμάτων από όπου υπήρχαν απόφοιτοι μουσικοθεραπευτές στη χώρα (Ηνωμένο Βασίλειο, Γερμανία, Φινλανδία και ΗΠΑ), ο ΣΥ.ΜΟΥ.Κ. και η νομοθετική υπηρεσία του Υπουργείου Υγείας κατέληξαν στα εξής (βλ. Παγκύπριος Δικηγορικός Σύλλογος, 2022):

1. «Πρόσωπο δικαιούται να εγγραφεί στο Μητρώο εάν ικανοποιήσει το συμβούλιο ότι είναι κάτοχος α) πανεπιστημιακού τίτλου ισότιμου και αντίστοιχου προς πτυχίο στη μουσικοθεραπεία⁵ αναγνωρισμένου βάσει του περί Αναγνώρισης Τίτλων Σπουδών Ανώτερης και Ανώτατης Εκπαίδευσης και Παροχή Σχετικών Πληροφοριών Νόμου, το οποίο περιλαμβάνει εποπτευόμενη πρακτική άσκηση που να συνάδει με τα εκάστοτε κριτήρια του Συμβουλίου ή β) πανεπιστημιακού διπλώματος ή ισότιμου πτυχίου στη μουσικοθεραπεία μη αναγνωρισμένου βάσει του περί Αναγνώρισης Τίτλων Σπουδών Ανώτερης και Ανώτατης Εκπαίδευσης και Παροχή Σχετικών Πληροφοριών Νόμου, το οποίο περιλαμβάνει εποπτευόμενη πρακτική άσκηση που να συνάδει με τα εκάστοτε κριτήρια του Συμβουλίου και άδεια ασκήσεως επαγγέλματος, η οποία ισχύει κατά το έτος που υποβάλλεται η αίτηση εγγραφής στο μητρώο, η οποία εκδίδεται από κράτος μέλος ή Τρίτη χώρα όπου το επάγγελμα είναι νομοθετικά κατοχυρωμένο» (σσ. 857-858).⁶
2. «Η Μουσικοθεραπεία σημαίνει το επάγγελμα υγείας κατά την άσκηση του οποίου χρησιμοποιούνται τεκμηριωμένες μουσικοθεραπευτικές πρακτικές, οι οποίες στηρίζονται στη χρήση της μουσικής και των στοιχείων της, προκειμένου να επιτευχθούν εξατομικευμένοι θεραπευτικοί στόχοι για τη βελτίωση της υγείας και της λειτουργικότητας του ατόμου στον κοινωνικό, επικοινωνιακό, μαθησιακό, ψυχικό, συναισθηματικό και σωματικό τομέα» (σελ. 854).
3. «Το Συμβούλιο Εγγραφής θα αποτελείται από επτά εκπροσώπους: (α) τρεις εγγεγραμμένους μουσικοθεραπευτές οι οποίοι κατέχουν θέση στη δημόσια εκπαιδευτική υπηρεσία, υπηρετούν στο Υ.Π.Π.Α.Ν. και ασκούν το επάγγελμα για τουλάχιστον 3 έτη, (β) τρεις εγγεγραμμένους μουσικοθεραπευτές οι οποίοι ασκούν ιδιωτικώς το επάγγελμα για τουλάχιστον 3 έτη και εκλέγονται από τη γενική συνέλευση του Συλλόγου, και (γ) 1 λειτουργό του Υπουργείου Υγείας» (σελ. 855).

⁵ Το ΚΥ.Σ.Α.Τ.Σ. από το 2016 αξιολογεί τα μεταπτυχιακά μουσικοθεραπείας μέσω μιας φόρμουλας ισοτιμίας/αντιστοιχίας. Σύμφωνα με αυτή τη φόρμουλα γίνεται συνεκτίμηση του πρώτου πτυχίου (Bachelor) του κάθε υποψηφίου (συνήθως πτυχίου στις μουσικές σπουδές) και του μεταπτυχιακού (Master) του στη μουσικοθεραπεία και ακολούθως, εάν πληροί τα κριτήρια, δίνεται πανεπιστημιακός τίτλος ισότιμος/αντίστοιχος προς πτυχίο στη μουσικοθεραπεία. Αυτό έγινε λόγω των σχεδίων υπηρεσίας του Υ.Π.Π.Α.Ν. όπου προκειμένου κάποιος μουσικοθεραπευτής να εργαστεί στα κρατικά σχολεία ειδικής αγωγής και εκπαίδευσης απαιτούν πτυχίο στη μουσικοθεραπεία.

⁶ Σε αυτή την περίπτωση μουσικοθεραπευτές που είναι απόφοιτοι π.χ. μεταπτυχιακών προγραμμάτων (Master) και κατέχουν άδεια ασκήσεως επαγγέλματος από χώρα όπου το επάγγελμα είναι νομοθετικά κατοχυρωμένο (π.χ. Ηνωμένο Βασίλειο) θα δικαιούνται να εγγραφούν στο μητρώο χωρίς να είναι απαραίτητο να περάσουν από τη διαδικασία συνεκτίμησης του ΚΥ.Σ.Α.Τ.Σ..

4. Οι εγγεγραμμένοι μουσικοθεραπευτές θα πρέπει να παρέχουν αποδεικτικά στοιχεία συνεχής επαγγελματικής εκπαίδευσης, τουλάχιστον 30 ωρών, κάθε δύο χρόνια με την ανανέωση της άδειας ασκήσεως.
5. Ο Σύλλογος Εγγεγραμμένων Μουσικοθεραπευτών και Πειθαρχική Επιτροπή συγκροτείται εντός 6 μηνών από την ψήφιση του νόμου.

Τον Ιούνιο του 2021 εκλέχτηκε νέος πρόεδρος της Επιτροπής Υγείας, ο οποίος πρότεινε στο ΣΥ.ΜΟΥ.Κ. να αποσύρει την αρχική πρόταση νόμου και να καταθέσει εκ νέου την πρόταση που είχε διαμορφωθεί σε συνεργασία με τη νομοθετική υπηρεσία του Υπουργείου Υγείας. Ο νέος πρόεδρος θεωρούσε ότι με αυτόν τον τρόπο θα είχαν την υποστήριξη περισσότερων μελών της Επιτροπής, καθώς η νέα πρόταση ήταν πιο ολοκληρωμένη και είχε ελεγχθεί από το αρμόδιο Υπουργείο Υγείας και τις σχετικές υπηρεσίες του κράτους.

Τον Οκτώβριο του 2021 η Επιτροπή Υγείας συνεδρίασε ξανά για να προχωρήσει τις διαδικασίες σχετικά με την πρόταση νόμου που καταθέσαμε. Σε αυτή τη συνεδρία καλέστηκαν όλοι σχετικοί κρατικοί φορείς και εκπρόσωποι του ΠΑ.ΣΥ.ΨΥ. Σε αυτή τη συνάντηση και προ εκπλήξεως του ΣΥ.ΜΟΥ.Κ. οι εκπρόσωποι του ΠΑ.ΣΥ.ΨΥ. έφεραν κάποιες ενστάσεις σχετικά με τον ορισμό της μουσικοθεραπείας και τον τρόπο που οι μουσικοθεραπευτές μπορούν να ασκήσουν το επάγγελμα τους. Συγκεκριμένα ανέφεραν:

Μη παροχή δυνατότητας αυτόνομης άσκησης καθηκόντων. Πάντοτε κατόπιν παραπομπής από επαγγελματίες στο τομέα της ψυχικής υγείας και στα πλαίσια λειτουργίας διεπαγγελματικής ομάδας η οποία θα έχει και την ευθύνη του ευρύτερου θεραπευτικού σχεδιασμού και επιστημονικής εποπτείας των οποιονδήποτε παρεμβάσεων. (Βουλή, 2021)

Αυτή η τοποθέτηση θεωρήθηκε από το ΣΥ.ΜΟΥ.Κ. άκρος λανθασμένη μιας και θα παρεμπόδιζε την άσκηση της μουσικοθεραπείας ως αυτόνομο επάγγελμα υγείας. Οι εκπρόσωποι του ΣΥ.ΜΟΥ.Κ. ξεκαθάρισαν ότι πάντοτε εργάζονται στα πλαίσια διεπαγγελματικού θεραπευτικού σχεδιασμού και πως δε χρειάζονται όλα τα περιστατικά παραπομπή από επαγγελματία της ψυχικής υγείας μιας και δεν αφορούν αποκλειστικά άτομα με ψυχικά νοσήματα. Μετά από αυτή την εξέλιξη, η αναπληρώτρια πρόεδρος της Επιτροπής μας παρότρυνε να κάνουμε μια κοινή συνάντηση ΣΥ.ΜΟΥ.Κ. και ΠΑ.ΣΥ.ΨΥ. έτσι ώστε να επιλυθεί η διαφωνία και να μπορέσει να προχωρήσει η Επιτροπή Υγείας στο μετέπειτα στάδιο.

Μέλη του ΣΥ.ΜΟΥ.Κ. προχώρησαν σε συνάντηση με τον ΠΑ.ΣΥ.ΨΥ. και αρχικά συμφώνησαν να προστεθεί στο εδάφιο που αναφέρετε στην άσκηση του επαγγέλματος του μουσικοθεραπευτή η εξής πρόνοια: «Μόνο σε ότι αφορά πολίτες με ποικίλα προβλήματα ψυχικής υγείας να γίνεται παραπομπή από ψυχίατρο ή κλινικό ψυχολόγο προκειμένου να λαμβάνουν υπηρεσίες μουσικοθεραπείας» (Βουλή, 2021). Ακολούθως, στάλθηκε υπόμνημα από το ΣΥ.ΜΟΥ.Κ. προς την Επιτροπή Υγείας με τις τροποποιήσεις που συμφωνήθηκαν. Παρόλες τις ενέργειες του ΣΥ.ΜΟΥ.Κ., ο ΠΑ.ΣΥ.ΨΥ. κατέθεσε εκ νέου υπόμνημα προς την Επιτροπή Υγείας όπου διευκρίνιζε ότι επιμένουν στην αρχική τους θέση και πως θεωρούν πως η μουσικοθεραπεία δεν μπορεί να λειτουργήσει ως

αυτόνομο επάγγελμα υγείας. Τελικά, η πράξη του ΠΑ.ΣΥ.ΨΥ. να προχωρήσει σε διαφορετική τοποθέτηση ενώ αρχικά είχαν συμφωνήσει σε άλλες θέσεις με το ΣΥ.ΜΟΥ.Κ. θεωρήθηκε παρατυπία και αγνοήθηκε.

Τον Δεκέμβριο του 2021, η Επιτροπή Υγείας διοργάνωσε νέα συνεδρίαση και κάλεσε όλους τους αρμόδιους κρατικούς φορείς να συμμετάσχουν. Σε αυτή τη συνεδρίαση διαβάστηκε η τροποποιημένη νομοθετική πρόταση και διατυπώθηκαν ορισμένες ενστάσεις. Συγκεκριμένα, ο εκπρόσωπος του Υ.Ε.Κ.Α. υποστήριξε ότι προτού προχωρήσει στη νομοθετική ρύθμιση του επαγγέλματος της μουσικοθεραπείας στην Κύπρο, οι αρμόδιες υπηρεσίες της βουλής θα πρέπει να εξετάσουν κατά πόσον το επάγγελμα της μουσικοθεραπείας είναι νομοθετικά ρυθμισμένο σε άλλες ευρωπαϊκές χώρες και τις πρακτικές κατοχύρωσης που εφαρμόζονται από άλλα κράτη στη βάση δεδομένων του Ευρωπαϊκού Κέντρου Κοινοβουλευτικής Έρευνας και Τεκμηρίωσης (European Centre of Parliamentary Research and Documentation, ECPRD). Επιπρόσθετα, ο εκπρόσωπος της Νομικής Υπηρεσίας επεσήμανε ότι πριν από την ψήφιση της νομοθεσίας θα πρέπει να διενεργηθεί αξιολόγηση αναλογικότητας όπως καθορίζει ο «περί του Ελέγχου Αναλογικότητας πριν από τη Θέσπιση Νέας Νομοθετικής Κατοχύρωσης των Επαγγελμάτων Νόμος του 2021» [Ν.. 174(I)/2021], για σκοπούς εναρμόνισης με την πράξη της Ευρωπαϊκής Κοινότητας με τίτλο «Οδηγία» (ΕΕ) 2018/958. Επίσης, ο εκπρόσωπος του Υπουργείου Υγείας ζήτησε να διατυπωθεί στον νόμο ότι: «άτομα με προβλήματα ψυχικής υγείας γίνονται δεκτά από μουσικοθεραπευτή μόνο μετά από παραπομπή ψυχιάτρου ή κλινικού ψυχολόγου». Ωστόσο, το παραπάνω αίτημα ερχόταν σε αντίθεση με τις διαδικασίες παραπομπής που ακολουθούν τα κρατικά σχολεία ειδικής αγωγής και εκπαίδευσης, οπότε ο εκπρόσωπος του Υ.Π.Π.Α.Ν. διαφώνησε. Τέλος, ο πρόεδρος της Επιτροπής δήλωσε ότι πριν από την επόμενη συνεδρίαση, το Υπουργείο Υγείας θα πρέπει να έχει διενεργήσει την αξιολόγηση αναλογικότητας, η Υπηρεσία Ερευνών, Μελετών και Εκδόσεων της Βουλής να έχει διεξαγάγει έρευνα σχετικά με τις νομοθεσίες του μουσικοθεραπευτικού επαγγέλματος σε άλλες ευρωπαϊκές χώρες, στη Σερβία, στο Ηνωμένο Βασίλειο και τις ΗΠΑ και ο ΣΥ.ΜΟΥ.Κ., το Υπουργείο Υγείας και το Υ.Π.Π.Α.Ν. θα πρέπει να έχουν συμφωνήσει σχετικά με τις διαδικασίες παραπομπής για άτομα με προβλήματα ψυχικής υγείας (βλ. Κυπριακή Δημοκρατία, 2022α).

Τον Μάρτιο του 2022, έγινε η τελική συνάντηση όλων των φορέων στην Επιτροπή Υγείας της Βουλής όπου η υπηρεσία ερευνών εξέδωσε το πόρισμά της έρευνας που διενήργησε. Σύμφωνα με την έρευνα, η μουσικοθεραπεία ρυθμίζεται νομοθετικά μόνο σε μία χώρα της Ευρωπαϊκής Ένωσης, την Αυστρία. Στη Λετονία και τη Λιθουανία το επάγγελμα του μουσικοθεραπευτή έχει αναγνωριστεί νομοθετικά ως επάγγελμα θεραπευτή τέχνης. Στο Ηνωμένο Βασίλειο η μουσικοθεραπεία ρυθμίζεται από το νόμο περί Συμπληρωματικών Επαγγελμάτων της Ιατρικής του 1960 που τροποποιήθηκε το 1997, για να συμπεριλάβει τους δημιουργικούς θεραπευτές (θεραπευτές τέχνης, μουσικοθεραπευτές και δραματοθεραπευτές). Η μουσικοθεραπεία συγκαταλέγεται ανάμεσα στα δεκαπέντε (15) συναφή επαγγέλματα υγείας (Allied Health Professions, AHPs) στο Εθνικό Σύστημα Υγείας του Ηνωμένου Βασιλείου (NHS). Ωστόσο, με βάση την εν λόγω έρευνα, παρά το ότι η μουσικοθεραπεία δεν αποτελεί κατά βάση νομοθετικά κατοχυρωμένο επάγγελμα, διδάσκεται σε πολλά δημόσια και ιδιωτικά πανεπιστήμια και εφαρμόζεται σε εθνικά συστήματα υγείας στην Ευρώπη. Περαιτέρω, σε ορισμένες χώρες, όπως η Σουηδία, η Εσθονία και η Ολλανδία, οι μουσικοθεραπευτές έχουν έναν ή περισσότερους συνδέσμους, οι οποίοι μεταξύ άλλων διαθέτουν

επαγγελματικό μητρώο των μελών τους και δεοντολογικό κώδικα (βλ. Κυπριακή Δημοκρατία, 2022β). Το πόρισμά της πιο πάνω έρευνας, είχε πολύ θετικό αντίκτυπο και στήριξε τη ρύθμιση του μουσικοθεραπευτικού επαγγέλματος στην Κύπρο.

Επιπρόσθετα, ο εκπρόσωπος του Υπουργείου Υγείας, διάβασε την έκθεση σχετικά με την αξιολόγηση αναλογικότητας και υποστήριξε την αναγκαιότητα ύπαρξης νομοθεσίας κυρίως για τη διασφάλιση της προστασίας των δικαιωμάτων των ατόμων στα οποία θα παρέχονται υπηρεσίες μουσικοθεραπείας (βλ. Κυπριακή Δημοκρατία, 2022α). Περαιτέρω, ο ΣΥ.ΜΟΥ.Κ. υπέβαλε νέο υπόμνημα για μια τελική τροποποίηση στη νομοθετική πρόταση. Σύμφωνα με το υπόμνημα, το Υπουργείο Υγείας, ο ΣΥ.ΜΟΥ.Κ. και το Υ.Π.Π.Α.Ν. συμφώνησαν ότι η ακόλουθη πρόνοια πρέπει να αναφέρεται στο νόμο:

Πρόσωπα με προβλήματα ψυχικής υγείας γίνονται δεκτά από μουσικοθεραπευτή μόνο κατόπιν παραπομπής από ψυχίατρο ή κλινικό ψυχολόγο: Νοείται ότι, οι πρόνοιες του παρόντος εδαφίου δεν εφαρμόζονται αναφορικά με την παροχή υπηρεσιών μουσικοθεραπείας σε σχολεία ειδικής αγωγής και εκπαίδευσης. (Παγκύπριος Δικηγορικός Σύλλογος, 2022, σελ. 859)

Στη συνέχεια, η Επιτροπή αποδέχθηκε τις τροποποιήσεις και επανεξέτασε όλα τα άρθρα της νομοθετικής πρότασης. Τέλος, ο πρόεδρος πρότεινε μια τελευταία συνάντηση, αυτή τη φορά μόνο μεταξύ των μελών της Επιτροπής, για να ελεγχθεί η τελική νομοθετική πρόταση πριν από την Ολομέλεια της Βουλής. Η τελική νομοθετική πρόταση διαμορφώθηκε από το νομοτεχνικό τμήμα της βουλής και περιελάβανε όλες τις τροποποιήσεις που είχαν εισηγηθεί και εγκριθεί από τους αρμόδιους κρατικούς φορείς.

Τον Απρίλιο του 2022, τα μέλη της Επιτροπής Υγείας συζήτησαν σε βάθος τη νομοθεσία και κατέληξαν στο συμπέρασμα ότι η νομοθεσία πρέπει να τεθεί προς ψήφιση στην Ολομέλεια της Βουλής.

Ο «νόμος που προβλέπει για την εγγραφή μουσικοθεραπευτών και για άλλα συναφή θέματα» ψηφίστηκε ομόφωνα στην Κύπρο από τη Βουλή των Αντιπροσώπων στις 5 Μαΐου του 2022. Οι βουλευτές όλων των πολιτικών κομμάτων υποστήριξαν τη νομοθεσία και τον καθοριστικό της ρόλο στην κατοχύρωση του μουσικοθεραπευτικού επαγγέλματος.

ΕΠΙΛΟΓΟΣ

Η θέσπιση νομοθεσίας που ρυθμίζει το επάγγελμα του μουσικοθεραπευτή στην Κύπρο αποτελεί ένα μεγάλο επίτευγμα. Η Κύπρος είναι πλέον η δεύτερη χώρα της Ευρωπαϊκής Ένωσης όπου το επάγγελμα ρυθμίζεται νομοθετικά ως επάγγελμα υγείας. Η αναγνώριση της μουσικοθεραπείας ως επάγγελμα Υγείας ανοίγει νέους δρόμους για την ένταξη των υπηρεσιών μουσικοθεραπείας στο Γενικό Σύστημα Υγείας, σε νοσοκομεία, εγκαταστάσεις ψυχικής υγείας και οίκους φροντίδας ηλικιωμένων. Κατ' επέκταση, η μουσικοθεραπεία δεν θα θεωρείται πλέον ως μια θεραπεία χρήσιμη μόνο για παιδιά με μαθησιακές δυσκολίες, αλλά ως μια θεραπευτική προσέγγιση που μπορεί να λειτουργήσει θετικά για μια ποικιλία περιστατικών.

Η ύπαρξη νόμου προστατεύει τόσο τον μουσικοθεραπευτή όσο και τον ασθενή μιας και καθορίζει με σαφήνεια το πλαίσιο εντός του οποίου οι επαγγελματίες μουσικοθεραπείας αποκτούν και διατηρούν την ικανότητα που απαιτείται για την παροχή υπηρεσιών μουσικοθεραπείας υψηλής ποιότητας. Με άλλα λόγια διασφαλίζει ότι οι παρεχόμενες υπηρεσίες μουσικοθεραπείας είναι ασφαλείς, αποτελεσματικές και έχουν ως επίκεντρο τον ασθενή.

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ΠΑΡΑΡΤΗΜΑ: ΑΝΤΙΤΥΠΟ ΥΠΟΜΝΗΜΑΤΟΣ⁷

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11 Μαρτίου, 2021

Θέμα: Ο περί Εγγραφής Μουσικοθεραπευτών Νόμος

Ο Σύνδεσμος Μουσικοθεραπείας Κύπρου, ως επίσημο οργανωμένο σύνολο καταρτισμένων μουσικοθεραπευτών στην Κύπρο (Αρ. μητρώου σωματείου 3658), ζητά όπως επανεξεταστεί από την Κοινοβουλευτική Επιτροπή Υγείας η πρόταση του Περί Εγγραφής Μουσικοθεραπευτών Νόμου, η οποία πλέον είναι κατεπείγον σημαντική.

Ως Σύνδεσμος, έχουμε διενεργήσει στο παρελθόν ακόμα δύο συναντήσεις με την Επιτροπή Υγείας της Βουλής, μια τον Οκτώβριο του 2010 και μια τον Ιούνιο του 2013, χωρίς όμως να έχουμε επιτύχει τα επιθυμητά αποτελέσματα. Εκ τότε, έχουν γίνει πολλές αλλαγές και ο αυξημένος αριθμός μουσικοθεραπευτών που εργάζεται στη χώρα μας επιβάλλει τη νομοθετική ρύθμιση του επαγγέλματος, χωρίς να αφήνει πολλά χρονικά περιθώρια αναβολής του.

Η θέσπιση νομοθεσίας του επαγγέλματος των μουσικοθεραπευτών είναι μείζονος σημασίας για τους εξής λόγους:

1. Το νομοθετικό πλαίσιο θα δρα προληπτικά σε πιθανά επικίνδυνα φαινόμενα που μπορούν εύκολα να προκύψουν λόγω της απουσίας του. Για παράδειγμα, παραπλάνηση, εκμετάλλευση και κερδοσκοπία σε βάρος των ασθενών από **μη-Μουσικοθεραπευτές**. Ο Σύνδεσμος έχει δεχτεί πάρα πολλές καταγγελίες σχετικά με άτομα που παρουσιάζουν τους εαυτούς τους ως μουσικοθεραπευτές ενώ δεν είναι και τα οποία εργάζονται σε Ιδρύματα ή άλλες δομές που σχετίζονται με ευάλωτες ομάδες. Δυστυχώς, λόγω της έλλειψης νομοθετικής κατοχύρωσης, ο Σύνδεσμος δεν μπορεί να παρέμβει, έτσι τα άτομα αυτά δρουν ανενόχλητα σε βάρος ευάλωτων ομάδων.
2. Θα διασφαλίζει τη σωστότερη δυνατόν άσκηση του επαγγέλματος του μουσικοθεραπευτή (π.χ. κριτήρια για εγγραφή στο Μητρώο, συνεχιζόμενη επαγγελματική ανάπτυξη) και ως εκ τούτου την ποιοτικότερη δυνατόν παροχή θεραπείας στον ευάλωτο πληθυσμό που καλείται ο μουσικοθεραπευτής να εξυπηρετήσει.
3. Το νομοθετικό πλαίσιο θα είναι το επίσημο σημείο αναφοράς για αμερόληπτη και ακριβή απεικόνιση της φύσης του επαγγέλματος και του επαγγελματία, για εξάλειψη σύγχυσης και αποπροσανατολισμού.

⁷ Το παρόν αντίτυπο δημοσιεύεται με την άδεια του Συνδέσμου Μουσικοθεραπείας Κύπρου.



4. Θα καταστεί επίσημο σημείο εκκίνησης για μια σωστή πορεία και ανέλιξη του επαγγέλματος, όπως και συμπερίληψής του στο ΓΕΣΥ, πράγμα που έχει ήδη γίνει για συναφή επαγγέλματα υγείας.
5. Οι μουσικοθεραπευτές χρήζουν ίσης μεταχείρισης με τους υπόλοιπους επαγγελματίες υγείας αναφορικά με τη διασφάλιση των επαγγελματικών τους καθηκόντων, όπως και των εργασιακών τους δικαιωμάτων.
6. Τέλος, πρέπει να σημειωθεί ότι το επάγγελμα της μουσικοθεραπείας ήδη ασκείται στην Κύπρο και ο ρυθμός ζήτησης και παροχής του αυξάνεται συνεχώς τα τελευταία χρόνια. Οι μουσικοθεραπευτές εργοδοτούνται τόσο από το Υπουργείο Υγείας, στις Υπηρεσίες Ψυχικής Υγείας (με αγορά υπηρεσιών), όσο και από το Υπουργείο Παιδείας, Πολιτισμού, Αθλητισμού και Νεολαίας στα Ειδικά Σχολεία. Η χρησιμότητα της μουσικοθεραπείας αποδεικνύεται από την αύξηση των μουσικοθεραπευτών στα Ειδικά Σχολεία. Από το 2017, το Υπουργείο Παιδείας, Πολιτισμού, Αθλητισμού και Νεολαίας διόρισε ακόμα δέκα μουσικοθεραπευτές, που σύμφωνα με τα στοιχεία διορισμών 2019-2020, το ποσοστό των έκτακτων έφτασε το 63,15%, το πιο ψηλό ποσοστό σε σύγκριση με τις υπόλοιπες ειδικότητες. Αυτό αδιαμφισβήτητα οφείλεται, σε ένα μεγάλο βαθμό, στην αποδοχή της συμβολής και αποτελεσματικότητας που έχει επιδείξει ο κλάδος. Έτσι, η θέσπιση νομοθεσίας γίνεται τάχιστα πιο αναγκαία για όλους τους πιο πάνω λόγους.

Αξίζει να σημειωθεί πως ο Σύνδεσμος έχει μελετήσει εκτενέστερα το θέμα των προσόντων για εγγραφή στο μητρώο (άρθρο 8 στην πρόταση), μετά από εκδήλωση διαφόρων απόψεων και προβληματισμών, κατά τη διάρκεια των προηγούμενων συνεδριών του 2010 και 2013. Οι προβληματισμοί επικεντρώνονταν κυρίως στο γεγονός ότι προτείνεται αναγνώριση Μεταπτυχιακού-Μαστερ στη Μουσικοθεραπεία, ως επαρκές προσόν για εγγραφή στο μητρώο. Ο Σύνδεσμος, από τότε έχει κάνει αρκετές ενέργειες ώστε να διασφαλίσει πως η κατάρτιση των μουσικοθεραπευτών με μαστερ από αναγνωρισμένα πανεπιστήμια του εξωτερικού είναι επαρκές προσόν:

1. Μετά από μια σειρά βημάτων του Συνδέσμου με εκπροσώπους του Υπουργείου Παιδείας, Πολιτισμού, Αθλητισμού και Νεολαίας και του ΚΥΣΑΤΣ, καταφέραμε να γίνεται συνεκτίμηση του μεταπτυχιακού τίτλου επιπέδου Master στη Μουσικοθεραπεία και του πρώτου πτυχίου των υποψηφίων και να δίνεται τίτλος ισότιμος και αντίστοιχος προς Πτυχίο πανεπιστημιακού επιπέδου στον κλάδο/ειδίκευση της Μουσικοθεραπείας.
2. Επίσης, πρέπει να τονίσουμε πως στις πλείστες περιπτώσεις όπου οι υποψήφιοι ήταν κάτοχοι μεταπτυχιακού στη Μουσικοθεραπεία, κατά τη συνεκτίμηση δεν υπολείπονταν μαθήματα σε σχέση με το πρότυπο πρόγραμμα σπουδών Μουσικοθεραπείας, όπως αυτό καθορίζεται από το ΚΥΣΑΤΣ.



3. Το ΚΥΣΑΤΣ μετά από συναντήσεις που κάναμε με την επιτροπή του, διόρισε, ως ανεξάρτητους κριτές, δυο ακαδημαϊκούς, εγνωσμένου κύρους, οι οποίοι είναι καθηγητές σε αναγνωρισμένα πανεπιστήμια του εξωτερικού, στον κλάδο της Μουσικοθεραπείας.

Επιπροσθέτως, θα πρέπει να τονίσουμε πως τα αναγνωρισμένα προγράμματα μουσικοθεραπείας, στις περισσότερες ευρωπαϊκές χώρες και ιδιαίτερα του Ηνωμένου Βασιλείου (από πού οι περισσότεροι Κύπριοι Μουσικοθεραπευτές είναι απόφοιτοι), είναι σε **Μεταπτυχιακό-Μάστερ** επίπεδο. Αυτά τα μεταπτυχιακά είναι σχεδιασμένα ώστε να προετοιμάσουν τον μουσικοθεραπευτή να μπορεί να ανταπεξέλθει σε ένα απαιτητικό τομέα, όπως είναι ο ευρύτερος τομέας της υγείας και να προσφέρει την καλύτερη ποιότητα υπηρεσιών. Περιλαμβάνουν κλινική εμπειρία και συνεχή εποπτεία.

Το Ηνωμένο Βασίλειο, είναι μία από τις τρεις Ευρωπαϊκές χώρες, μαζί με την Αυστρία και τη Λετονία, όπου το επάγγελμα του μουσικοθεραπευτή διέπεται από ανάλογη νομοθεσία από το 1996. Όσον αφορά στις σπουδές και στην διαδικασία αναγνώρισης της μουσικοθεραπείας στο Ηνωμένο Βασίλειο, έχει γίνει μια εκτενής αξιολόγηση των Μουσικοθεραπευτών που έπρεπε για αρκετό καιρό, γι' αυτόν τον λόγο, να συνεργαστούν με το Υπουργείο Υγείας (Department of Health-DoH). Αφού συλλέχθηκαν αρκετά στοιχεία για την επίδραση και αποτελεσματικότητα της συνεισφοράς της μουσικοθεραπείας ως επάγγελμα υγείας, τότε οι μουσικοθεραπευτές μπορούσαν να υποβάλουν αίτηση στο τότε Συμβούλιο Επαγγελματιών Υγείας (Health Professions Council-HPC, το οποίο ενεργεί ως Συμβούλιο Εγγραφής 20 περίπου Επαγγελματιών Υγείας). Εφόσον η αίτηση γινόταν αποδεκτή, τότε θα μπορούσε να περάσει προς κοινοβουλευτική ψήφιση και οι μουσικοθεραπευτές σε επαγγελματική κατοχύρωση (από τα πρακτικά της Γενικής Συνέλευσης της Ευρωπαϊκής Συνομοσπονδίας Μουσικοθεραπείας (EMTC) στο Ταλλίν τον Ιούνιο του 2012 – αναφορά της Τέσσα Ουότσον, εκπροσώπου Ηνωμένου Βασιλείου στο θέμα αναγνώριση/εγγραφή).

Επιπλέον, είναι ευρέως αποδεκτό πως το εκπαιδευτικό και το επαγγελματικό επίπεδο στο Ηνωμένο Βασίλειο είναι από τα πλέον αξιόπιστα στην Ευρώπη. Αναφερόμαστε στο παράδειγμα του Ηνωμένου Βασιλείου γιατί οφείλουμε να λάβουμε σοβαρά υπόψη τις τάσεις χωρών όπου το επάγγελμα είναι ήδη εδραιωμένο και κατοχυρωμένο, ιδιαίτερα λόγω του ότι δεν υπάρχει ακόμη αναγνωρισμένο πανεπιστημιακό πρόγραμμα στον τομέα της μουσικοθεραπείας στην Κύπρο, αλλά ούτε και στην Ελλάδα, για να υπάρξει έγκυρο μέτρο σύγκρισης.

Εν κατακλείδι και λαμβάνοντας υπόψη όλα τα παραπάνω, πιστεύουμε ότι είναι σημαντικό να υπάρξει, σε αυτό το εξελικτικό στάδιο, ανάλογη νομοθεσία που να ρυθμίζει το επάγγελμα όπως και Συμβούλιο Εγγραφής που θα πιστοποιεί την κατάρτιση του μουσικοθεραπευτή και θα κατευθύνει προς τακτική συνεχιζόμενη επαγγελματική ανάπτυξη, για την πιο ποιοτική παροχή θεραπειών. Με αυτόν τον τρόπο θα προστατεύεται στο μέγιστο, οποιοδήποτε άτομο παραπέμπεται, χρειάζεται, επιζητεί και λαμβάνει τις υπηρεσίες μουσικοθεραπείας, όπως και θα διασφαλίζεται και το δικαίωμα που έχουν οι μουσικοθεραπευτές να είναι αναγνωρισμένο και



κατοχυρωμένο επάγγελμα υγείας, ακολουθώντας τα πρότυπα εργασίας που επικρατούν στις υπόλοιπες Ευρωπαϊκές και ανεπτυγμένες χώρες.

Εκ Μέρους του Συνδέσμου Μουσικοθεραπείας Κύπρου

Αντωνία Πλυσή
(Πρόεδρος)

English abstract | Αγγλική περίληψη

The process of the legislative regulation of the music therapy profession in Cyprus

Antonia Plysi | Panagiota Kapnisi

ABSTRACT

On 5th May 2022, a law on the registration of music therapists and other related matters [N.68(1)2022] was unanimously ratified by the House of Representatives in Cyprus. This report describes in detail the process that the Cyprus Music Therapy Association (CyMTA) followed in order to achieve legislative regulation of the music therapy profession. Before analysing the regulation process, we present a short introduction to Cyprus' history to clarify the particular political situation of the country. Then, we provide a historical review of the development of music therapy and the music therapy profession in Cyprus. Finally, we describe the Cypriot constitutional framework, as the statutory consolidation of the music therapy profession in Cyprus was mainly achieved through constitutional procedures.

KEYWORDS

Cyprus, music therapy law, statutory consolidation, health profession, legislative regulation

ΣΧΟΛΙΑΣΜΟΣ

Ένα σχολιασμός για την αναφορά «Η πορεία της νομοθετικής ρύθμισης του επαγγέλματος της μουσικοθεραπείας στην Κύπρο» (Πλυσή & Καπνίση)

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ΒΙΟΓΡΑΦΙΑ ΣΥΓΓΡΑΦΕΑ

Η Χριστίνα Καλλιώδη, MA, NICU, MIT είναι επίτιμη μουσικοθεραπεύτρια και ψυχοθεραπεύτρια. Ιδρύτρια του Κέντρου Μουσικής Ψυχοθεραπείας «ηχώ» όπου εργάζεται με παιδιά και ενήλικους και συνεργάτης της AMKE «Άγγελοι της Χαράς» υπεύθυνη του προγράμματος μουσικοθεραπείας στη Μονάδα Εντατικής Νοσηλείας Νεογνών του ΓΝΠ «Παναγιώτη και Αγλαΐας Κυριακού». Έχει υπηρετήσει ως Πρόεδρος του ΕΣΠΕΜ και αντιπρόσωπός του στην Ευρωπαϊκή Συνομοσπονδία Μουσικοθεραπείας. [christina.kalliodi@nxw.gr]

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Η περιπετειώδης διαδρομή των Κυπρίων μουσικοθεραπευτών όπως περιγράφεται στο άρθρο των Πλυσή και Καπνίση (2023) «Η Πορεία της Νομοθετικής Ρύθμισης του Επαγγέλματος της Μουσικοθεραπείας στην Κύπρο», με οδήγησε αναπόφευκτα στη σύγκριση με την ελληνική πραγματικότητα, και έγινε αφορμή για σκέψη και προβληματισμό.

Καταρχάς θαύμασα τη συνέπεια, την οργάνωση και τη μεθοδικότητα των συναδέλφων του Συνδέσμου Μουσικοθεραπείας Κύπρου (ΣΥ.ΜΟΥ.Κ.) σε όλη τη διάρκεια της προσπάθειάς τους σε αντίθεση με τον τρόπο που ο Ελληνικός Σύλλογος Πτυχιούχων Επαγγελματιών Μουσικοθεραπευτών (ΕΣΠΕΜ) έχει διαχειριστεί το συγκεκριμένο ζήτημα. Έχοντας υπηρετήσει επί σειρά ετών σε διαφορετικές θέσεις στον Σύλλογο (εκπρόσωπός του στην Ευρωπαϊκή Συνομοσπονδία Μουσικοθεραπείας, ταμίας και πρόεδρος) θεωρώ πως οι προσπάθειές μας ήταν μάλλον αποσπασματικές, χωρίς ουσιαστική νομική καθοδήγηση και με μια αίσθηση ότι αντί να αναλαμβάνουμε πρωτοβουλία τρέχουμε πίσω από τις εξελίξεις. Οι λόγοι θα πρέπει ίσως να αναζητηθούν στον διαφορετικό τρόπο κρατικής οργάνωσης και λήψης αποφάσεων, αλλά οπωσδήποτε και στις δυναμικές σχέσεις, ζητήματα ελέγχου, δημοκρατικότητας, συμμετοχής, καθώς και άλλες προκλήσεις που διαχρονικά αντιμετωπίζει η επαγγελματική μας κοινότητα (Ακογυνογλου, 2023· Τσιρίσις, 2011· Τσιρίσις & Καλλιώδη, 2020· Καλλιώδη κ.ά., 2023).

Για αρκετά χρόνια η κατάσταση στις δύο χώρες φαινόταν παρόμοια. Το επάγγελμα δεν ρυθμιζόταν νομοθετικά με συνέπεια την πληθώρα προσφερόμενων υπηρεσιών από ανθρώπους χωρίς την κατάλληλη εκπαίδευση, ενώ σπουδές μουσικοθεραπείας μπορούσαν να πραγματοποιηθούν μόνο στο εξωτερικό. Υπήρχαν και υπάρχουν όμως αρκετές διαφορές:

Παρά την έλλειψη ρύθμισης, η ειδικότητα του μουσικοθεραπευτή -με απαιτούμενο προσόν το πτυχίο μουσικοθεραπείας- εισήχθη ήδη από το 1999 στα κρατικά σχολεία ειδικής αγωγής και

εκπαίδευσης της Κύπρου. Το 2008, αντίστοιχη πρωτοβουλία του ελληνικού κράτους (Νόμος 3699/2008, άρθρο 20, παρ. 2.2) που για πρώτη φορά όριζε τον κλάδο ΠΕ36 μουσικοθεραπευτών δεν προχώρησε ποτέ. Ο προσδιορισμός των προσόντων του μουσικοθεραπευτή (αρκούσε το πτυχίο σε κάποιο μουσικό όργανο) έδειχνε άγνοια για τη διαφορά ανάμεσα στη μουσική εκπαίδευση, την ειδική αγωγή και τη μουσικοθεραπεία (Tsiris, 2011). Παρά τις ενστάσεις του ΕΣΠΕΜ, ο νόμος ψηφίστηκε ως είχε, ωστόσο ευτυχώς δεν πραγματοποιήθηκε έως σήμερα προκήρυξη για τον κλάδο ΠΕ36, μιας και κάτι τέτοιο θα σήμαινε ότι άνθρωποι χωρίς την απαραίτητη εκπαίδευση θα καλούνταν να παρέχουν υπηρεσίες μουσικοθεραπείας.

Στην Κύπρο η διορισμένη από το Υπουργείο Παιδείας «Ειδική Επιτροπή για Μελέτη Τρόπων Παροχής Βοήθειας στα Παιδιά με Ειδικές Ανάγκες» περιλάμβανε τη μουσικοθεραπεύτρια Ανθή Αγρότου, η οποία εισήγαγε το επάγγελμα στη χώρα (βλ. Αγρότου, 2014). Στην Ελλάδα -εξ όσων τεκμηριωμένα γνωρίζω- ουδέποτε υπήρξε σχετική πρόσκληση έστω για γνωμοδότηση, από κανέναν φορέα σχεδιασμού των χώρων της εκπαίδευσης και της υγείας. Πιο πρόσφατο παράδειγμα, η παντελής απουσία των μουσικοθεραπευτών από τις διεργασίες για το πολυδιαφημισμένο πρόγραμμα «Πολιτιστικής Συνταγογράφησης» που σύμφωνα με το Υπουργείο Πολιτισμού (2023) στοχεύει στην «αξιοποίηση της ερευνητικά αποδεδειγμένης θεραπευτικής λειτουργίας της τέχνης στην ψυχική υγεία». Παρά το γεγονός ότι υπάρχουν πλέον δύο συνάδελφοι μουσικοθεραπευτές εκλεγμένα μέλη ΔΕΠ σε ελληνικά πανεπιστήμια, ουδείς εκλήθη να συμμετέχει ούτε στην ερευνητική ομάδα που έχει αναλάβει τον σχεδιασμό, την εφαρμογή και την αξιολόγηση των επιμέρους πιλοτικών δράσεων, αλλά ούτε και στη Διυπουργική Ομάδα Εργασίας η οποία θα προσδιορίσει τις προϋποθέσεις και τις απαραίτητες ενέργειες για την ένταξη της Πολιτιστικής Συνταγογράφησης στο Εθνικό Σύστημα Υγείας.

Διαφορά εντοπίζεται και στο ζήτημα της διαρκούς επαγγελματικής εξέλιξης. Στην Κύπρο, καθίσταται υποχρεωτική από τον νομοθέτη καθορίζοντας δραστηριότητες 30 ωρών ανά διετία ως προϋπόθεση για την ανανέωση της άδειας ασκήσεως του επαγγέλματος. Στην Ελλάδα, ο καθορισμός των ελάχιστων απαιτούμενων δραστηριοτήτων διαρκούς επαγγελματικής εξέλιξης που θα απαιτεί ο ΕΣΠΕΜ από τα μέλη του αποτελεί αντικείμενο μακροχρόνιας συζήτησης και διαφωνιών χωρίς ακόμη να οριστικοποιείται. Επιπλέον και παρά τις κατευθυντήριες γραμμές της Ευρωπαϊκής Συνομοσπονδίας Μουσικοθεραπείας (χ.χ.) που την θεωρεί υποχρεωτική για όλους, υπάρχει έντονη απαίτηση η διαρκής επαγγελματική εξέλιξη να αφορά μόνο τους επόπτες και έχει εκφραστεί η άποψη πως η υποχρεωτικότητά της θα απέτρεπε τους συναδέλφους από την εγγραφή στον Σύλλογο.

Τέλος, στην Ελλάδα, από το 2016 με την ίδρυση της κατεύθυνσης Μουσικοθεραπείας του μεταπτυχιακού προγράμματος Μουσική και Κοινωνία του Πανεπιστημίου Μακεδονίας υπάρχουν πλέον πανεπιστημιακές σπουδές μουσικοθεραπείας. Ταυτόχρονα όμως, σε αντίθεση με την Κύπρο, υπάρχει και πλήθος εκπαιδευτικών προγραμμάτων που λειτουργούν ανεξέλεγκτα χωρίς εξειδικευμένο διδακτικό προσωπικό, των οποίων οι όλο και περισσότεροι απόφοιτοι χρησιμοποιούν τον τίτλο του μουσικοθεραπευτή.

Μια βασική δυσκολία που έπρεπε να αντιμετωπίσει ο ΣΥ.ΜΟΥ.Κ. ήταν η στάση του Παγκύπριου Συνδέσμου Ψυχολόγων ο οποίος θεωρούσε ότι οι μουσικοθεραπευτές δεν θα έπρεπε να έχουν τη «δυνατότητα αυτόνομης άσκησης καθηκόντων» (σ. 7), αλλά και πως δεν είναι επαρκώς καταρτισμένοι «για να αναλαμβάνουν περιστατικά με θέματα ψυχικής υγείας» (σ. 4). Αντίστοιχες

στάσεις και προκαταλήψεις συναντάμε και στην Ελλάδα. Συγκεκριμένα, κατά τη διάρκεια των διαβουλεύσεων για το νόμο 3699 του 2008, το Υπουργείο μας είχε ενημερώσει προφορικά πως υπήρξαν ενστάσεις από άλλες ειδικότητες για τη συμμετοχή των μουσικοθεραπευτών στα κέντρα διάγνωσης και αξιολόγησης, ενώ πρόσφατα –σε προσωπικό επίπεδο– μια Ελληνίδα ψυχολόγος κατέκρινε το γεγονός ότι εργαζομαι αυτόνομα με ανθρώπους με δυσκολίες ψυχικής υγείας, θεωρώντας πως δεν έχω τα απαραίτητα εφόδια και θα έπρεπε να ασκώ τη μουσικοθεραπεία μόνο υπό την εποπτεία ψυχολόγου.¹

Επίσης, στην Ελλάδα, οι άλλες Θεραπείες μέσω Τεχνών (Δραματοθεραπεία, Εικαστική Θεραπεία και Χοροκινητική Θεραπεία) τείνουν να ονομάζονται «Ψυχοθεραπείες μέσω Τεχνών» και, σε αντίθεση με τη μουσικοθεραπεία, δεν διδάσκονται σε πανεπιστημιακό επίπεδο, αλλά σε ιδιωτικά προγράμματα μερικής φοίτησης διάρκειας 3-5 ετών. Σε πολλές προσωπικές, αλλά και συνδικαλιστικές συζητήσεις, έχει εκφραστεί η άποψη ότι οι διετείς μεταπτυχιακές σπουδές μουσικοθεραπείας είναι υποδεέστερες αυτών των εκπαιδεύσεων, ενώ συχνά διατυπώνεται από άλλους επαγγελματίες υγείας και η θέση πως οι Θεραπευτές μέσω Τεχνών θα έπρεπε να έχουν απαραίτητα πτυχίο στη Ψυχολογία. Είναι επίσης σύνηθες το φαινόμενο σε συζητήσεις και εκδηλώσεις για τη μουσικοθεραπεία ή τη μουσική στην υγεία ο λόγος γιατρών και ψυχολόγων χωρίς σπουδές στο αντικείμενο να έχει περισσότερο βάρος από τον λόγο ενός μουσικοθεραπευτή. Θυμάμαι, ακόμη, την –συχνή στο παρελθόν– προτροπή να θέτουμε τις ενημερωτικές εκδηλώσεις του ΕΣΠΕΜ υπό την αιγίδα άλλων επιστημονικών φορέων και να προσκαλούμε γιατρούς ως ομιλητές, ώστε τα λεγόμενά μας να αποκτούν «κύρος και επιστημονικότητα». Παρόμοιες απόψεις διατυπώνονται συνήθως χωρίς γνώση του αντικειμένου της μουσικοθεραπείας και το περιεχόμενο των σπουδών μας σε ένα πλαίσιο πολύπλοκων δυναμικών σχέσεων που επικρατούν στον ευρύτερο χώρο των επαγγελμάτων της υγείας, της φροντίδας και της εκπαίδευσης, μεταξύ των διαφορετικών ειδικοτήτων που προσπαθούν να διασαφηνίσουν και να οριοθετήσουν τη θέση και τον ρόλο τους.

Ιδιαίτερα ενδιαφέρον –και μάλλον ασυνήθιστο για τα ευρωπαϊκά δεδομένα– είναι το γεγονός ότι η αναγνώριση και ρύθμιση του επαγγέλματος στην Κύπρο δεν προϋπέθετε την ύπαρξη εγχώριου εκπαιδευτικού προγράμματος, αλλά και ότι δεν ορίζεται σαφές πεδίο επαγγελματικής δραστηριότητας και αρμοδιοτήτων. Φαίνεται ότι ο νομοθέτης δεν επεδίωξε να προσδιορίσει τις απαιτούμενες δεξιότητες ενός μουσικοθεραπευτή, ούτε να ελέγξει αν αυτές καλύπτονται από τους διαφορετικού τύπου τίτλους που αναγνωρίζει.² Δείχνει να θεωρεί a priori ισοδύναμους όλους τους τίτλους σπουδών ανεξαρτήτως επιπέδου, αριθμού ECTS, περιεχομένου, διάρκειας και εξειδίκευσης. Μήπως, όμως, θα έπρεπε να αντιμετωπίζονται διαφορετικά σε πρακτικό, κλινικό ή/και μισθολογικό επίπεδο; Για παράδειγμα, ο απόφοιτος ενός εξ αποστάσεως μεταπτυχιακού

¹ Στην πλειοψηφία των ευρωπαϊκών χωρών που η μουσικοθεραπεία ρυθμίζεται νομοθετικά, οι μουσικοθεραπευτές εργαζονται αυτόνομα ή ως ισότιμα μέλη διεπιστημονικών ομάδων και μπορούν ελεύθερα να επιλέγουν τον επόπτη τους, ο οποίος μπορεί να είναι μουσικοθεραπευτής ή να προέρχεται από άλλη ειδικότητα. Σε κάποιες από αυτές αυτόνομα μπορούν να εργαστούν μόνο οι μουσικοθεραπευτές με μεταπτυχιακό κύκλο σπουδών ή ολοκληρώνοντας μια διαδικασία πιστοποίησης μετά το πέρας των σπουδών τους (EMTC, χ.χ.).

² Η αναγνώριση των τίτλων σπουδών μουσικοθεραπείας γίνεται μέσω του Κυπριακού Συμβουλίου Αναγνώρισης Τίτλων Σπουδών (ΚΥ.Σ.Α.Τ.Σ.). Οι σχετικές αιτήσεις αξιολογούνται από δύο μουσικοθεραπευτές εξωτερικά μέλη του πεδίου που μετά από προτροπή του ΣΥ.ΜΟΥ.Κ. έχουν διοριστεί στο Μητρώο Ανεξάρτητων Κριτών.

προγράμματος μουσικοθεραπείας, που δεν απαιτεί προσωπική θεραπεία και του οποίου η κλινική άσκηση περιλάμβανε αποκλειστικά την υποστήριξη της ανάπτυξης κινητικών δεξιοτήτων σε ανθρώπους με εγκεφαλικό τραύμα, είναι επαρκώς προετοιμασμένος να εργαστεί ως αυτοαπασχολούμενος ιδιώτης με ανθρώπους με δυσκολίες ψυχικής υγείας; Έχει τις ίδιες δεξιότητες και δυνατότητες προσαρμογής με τον απόφοιτο προγράμματος ο οποίος έχει πραγματοποιήσει κλινική άσκηση με ανθρώπους με διαφορετικές ανάγκες και δυσκολίες, σε διαφορετικά πλαίσια και έχει βρεθεί –ως υποχρεωτικό και αναπόσπαστο μέρος της κατάρτισής του– σε προσωπική ατομική και ομαδική θεραπευτική διαδικασία διάρκειας;

Ένας τελευταίος προβληματισμός σχετικά με τη νομοθεσία της Κύπρου αφορά τη δυνατότητα των ανθρώπων με θέματα ψυχικής υγείας να έχουν πρόσβαση σε υπηρεσίες μουσικοθεραπείας μόνο «κατόπιν παραπομπής από ψυχίατρο ή κλινικό ψυχολόγο» (σ. 9). Κάτι τέτοιο προϋποθέτει κατ' αρχάς, πως κάθε ψυχίατρος και κλινικός ψυχολόγος γνωρίζει τις απαραίτητες πληροφορίες για τη μουσικοθεραπεία, ώστε να παραπέμψει αναλόγως. Πόσο, όμως, ηθικά ή δεοντολογικά ορθό είναι το γεγονός ότι ένας άνθρωπος με θέματα ψυχικής υγείας στερείται του δικαιώματος να επιλέξει ελεύθερα τη θεραπευτική προσέγγιση (κύρια ή συμπληρωματική), μέσω της οποίας επιθυμεί να αντιμετωπίσει τις δυσκολίες του;

Ελπίζω πως η ελληνική μουσικοθεραπευτική κοινότητα θα ασχοληθεί πιο ενεργά, με μεγαλύτερη συνέπεια, οργάνωση και μεθοδικότητα προς την προσπάθεια νομοθετικής αναγνώρισης και ρύθμισης της ειδικότητάς μας. Μια τέτοια προσπάθεια, όμως, θα έχει πραγματικό θετικό αντίκτυπο για το επάγγελμα και το πεδίο, μόνο αν δεν εξαντληθεί σε μια αφηρημένη αναγνώριση με αποκλειστικό στόχο την επαγγελματική αποκατάσταση. Πιστεύω πως το ουσιαστικό όφελος ενός τέτοιου εγχειρήματος θα προκύψει εάν ασχοληθούμε σε βάθος με τον τρόπο και το περιεχόμενο της απαιτούμενης εκπαίδευσης, θέτοντας κατάλληλα κριτήρια, αλλά και με τον ακριβή προσδιορισμό της επαγγελματικής δραστηριότητας και αρμοδιοτήτων, ώστε να αναδεικνύονται και να αξιοποιούνται οι πολλαπλές εφαρμογές της μουσικοθεραπείας και το εύρος των δεξιοτήτων των μουσικοθεραπευτών. Για να προχωρήσουμε θα χρειαστεί εξειδικευμένη νομική καθοδήγηση και υποστήριξη, διασύνδεση με άλλους επαγγελματικούς και επιστημονικούς φορείς –ένα θετικό βήμα είναι η συμμετοχή του ΕΣΠΕΜ στο νεοσύστατο Δίκτυο Ψυχοθεραπειών/Θεραπειών μέσω Τεχνών (Ένωση Δραματοθεραπευτών και Παιγνιοθεραπευτών Ελλάδας, 2024)–, αλλά ίσως σημαντικότερα ένας ανοιχτός συνεργατικός και τεκμηριωμένος διάλογος μεταξύ των μελών της μουσικοθεραπευτικής κοινότητας (ΕΣΠΕΜ, πανεπιστήμια, μουσικοθεραπευτές στο πεδίο) για τη συνδημιουργία κοινής γλώσσας, οράματος και σχεδιασμού για το μέλλον.

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COMMENTARY

A commentary on “An analysis of caregiver perceptions of early childhood music therapy telehealth groups” (Knight & Blank)

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The COVID-19 pandemic posed an unprecedented challenge for service providers, particularly in essential services such as healthcare and education. Many providers rose to the challenge through telehealth delivery, music therapy being no exception (Clements-Cortes et al., 2023). An unexpected silver lining of this crisis was the increased awareness that such a telehealth delivery mode has, in fact, the potential to remain in our toolbox as it has increased healthcare and educational access of underserved communities (e.g., Cole et al., 2021). However, those benefits do not come without drawbacks. Anyone who has experienced a virtual session can attest to the difficulties presented by limited or inefficient technology, a lack of expertise in its use, technical limitations specific to synchronous music-making, and the challenges of nonverbal communication in the virtual setting. As we emerge from the immediate crisis, we continue to examine best practices in telehealth music therapy. Knight and Blank (2025) engage in precisely this evaluation and reflection by analysing caregiver perceptions of early childhood music therapy telehealth groups. Their study is welcomed and timely.

The following is a commentary on Knight and Blank’s (2025) article, *An analysis of caregiver perceptions of early childhood music therapy telehealth groups*, published in *Approaches* earlier in 2025. I approach the commentary from the perspective of a music therapy researcher, educator, and clinician, trained in the US, with clinical experience in my home country, Mexico, and currently a tenured faculty member at a US university. I was initially trained in behavioural models of music therapy, but this has been enriched by specialised training in autism interventions with a developmental and naturalistic perspective, parent coaching of those interventions, and brief family therapy. From the latter, I have espoused a family systems approach, where working with the family (specifically, the parents) becomes an essential ingredient of change for the autistic child. My own research on

telehealth music therapy and virtual parent coaching of music interventions generates both biases and empathy towards the difficulties and strengths of conducting a study in this modality.

Knight and Blank (2025) interviewed six parents and legal guardians (PLG) and five early childhood practitioners (ECP) who were caregivers to children participating in a 12-week virtual music therapy programme during 2020 and 2021. The interviews explored PLGs and ECPs perceptions of the programme. Researchers engaged in thematic analysis of the interviews.

Overall, the study is interesting and explores the acceptability of telehealth in early childhood settings. The interventionists were professionals and interns, and the interviewing researchers were not previously known to the participants. This is a strength that highlights the value of co-designing an investigation with a group of clinicians. By separating roles, we can assume that researchers got more naïve responses. On the other hand, although researchers sent themes to expert music therapists for “member check,” there was no explicit mention of participant check, which was an intriguing methodological choice.

Regarding the theoretical framework, I was also intrigued by the absence of a significant body of recent literature that has addressed music therapy and caregivers (e.g., Gottfried et al., 2022; Jacobsen et al., 2014; Kern et al., 2007; Oldfield & Flower, 2008; Pienaar, 2012; Thompson, 2017; Shoemark, 1996; Yang, 2015; Yates et al., 2018 to name a few) and telehealth music therapy and caregivers (e.g., Baker & Tamplin, 2021; Brault & Vaillancourt, 2022; Hernandez-Ruiz, 2023; Kantorova et al, 2021; McLeod & Starr, 2021). Although several, but not all, of these studies occur outside of an early childhood setting, the findings regarding caregivers’ perceptions of music therapy and of telehealth music therapy are similar and seem worth comparing. With the studies that do involve early education settings, the parallels are even more apparent, which makes their absence in the literature review conspicuous.

Several methodological choices were thought-provoking. After careful consideration, I agree with some, but for others, I would still like deeper explanations. For example, the researchers justified their choice of integrating Early Childhood Practitioners’ (ECP) perspectives with those of Parent and Legal Guardians’ (PLG) by alluding to Bronfenbrenner’s Ecological Theory, which posits that both groups play a significant role in the child’s microsystem. This is indeed a convincing argument. Knight and Blank also use attachment theory as part of the theoretical framework that explicates the value of including these groups in their analysis. Although I wholeheartedly agree with the notion that ECPs and PLGs are meaningful for young children and serve as attachment figures, the quality and impact of those attachments are considerably different. A paid, certified professional ECP, in charge of a group and not only of an individual child, would certainly establish a different relationship with a child than their own parent or legal guardian. Not only the amount of time spent together, but the quality of the interaction differs drastically.

Another area that provided much food for thought was the researchers’ choice to mix perspectives from participants in in-home sessions with those from an early childhood centre, as well as participants in individual and group sessions. At face value, this mix does not seem a sound methodological choice. As with ECP and PLG differences, home and centre settings differ substantially. The opportunities, environmental setups, and resources are very different. Regarding group vs. individual sessions, one could argue that a child in a group setting would pay more attention

to the adults and children sharing the space than to a person on a screen. Contrastingly, a single child sitting in front of a screen, prompted by a parent, may direct their attention more easily to the interventionist. The amount of work and the prompting that the ECP and the PLG caregiver thus provided may not be comparable. Their perspectives on the programme would yield very different results.

However, researchers very astutely compared and contrasted ECP and PLG perceptions, revealing a three-level categorisation of themes that is quite interesting. Themes unique to PLG included home musicality, socialisation with siblings, and difficulties in the flow of information among the centre, the PLGs, and the music therapists. Unique themes to ECPs included the usefulness of music therapy elements in the classroom and the relevance of emotional regulation practices in everyday behaviours. Both groups mentioned technology barriers and benefits of music therapy sessions as important themes. The careful analysis of these two perspectives, combined and contrasted, produced interesting conclusions that can be used in future programming. For example, music therapists working with PLG and ECPs in a telehealth model would be wise to create a clear communication system, inform PLGs of music therapy principles and effects, and educate ECPs on technology use before attempting such a programme.

Another important methodological choice was to include participants with different needs for support. Outside of this study, participant children had been “classified” through a Response-to-Intervention model (Pierangelo & Giuliani, 2008) in different tiers according to their needs for support. In this study, students at levels 2 and 3, corresponding to higher needs, were offered individual music therapy sessions in addition to or in place of group sessions. Although I understand this choice from a programmatic perspective, researchers did not acknowledge the different effect that such participation would have on caregivers’ perceptions. As mentioned, the amount of involvement that PLGs and ECPs had differed based on individual/group and home/centre settings. This discrepancy in services also raises concerns about inclusive practices that allow students to be educated in the least restrictive environment. I was left wanting a deeper explanation of these choices. These aspects should be addressed in future research and iterations of the programme.

Another point where I would have liked more information was the intervention programme itself. The authors mention that each session was based on “different goals and objectives for the children in those sessions” (p. 5). I empathise with the difficulties in creating succinct descriptions of complex programmes that accurately reflect the multitude of in-the-moment choices interventionists make. A description, even if general, of the music therapy programme would have made this study more translatable to practice. That said, it is clear that the intent of this study is not to evaluate programme efficacy, but to understand caregiver perspectives. The study does that effectively. Helping readers contextualise those perceptions to a specific programme would have made this study even more beneficial.

Finally, and I must admit my own bias towards explicitly distinguishing therapeutic roles, I was curious about the lack of discussion of alternative roles for the music therapist. Several authors have long considered consultation a viable role for music therapists (Kern et al., 2007; Register, 2002; Rickson, 2010; Steele, 2020). In the telehealth setting, being a consultant rather than a direct interventionist seems to be especially beneficial, as adult caregivers are better equipped to follow

instructions than children (e.g., Hernandez-Ruiz, 2023). Although direct services were the focus of this programme, a discussion of alternative roles to address technological and communication difficulties seemed warranted.

Telehealth delivery of music therapy programmes has demonstrated its value and has become an essential tool for music therapists (Clements-Cortes et al., 2023; Cole et al., 2021). Continuing to research its efficacy, reporting accuracy, fidelity, cost effectiveness, training needs, and consumer perspectives of complex programmes engages clinicians and researchers in fruitful conversations.

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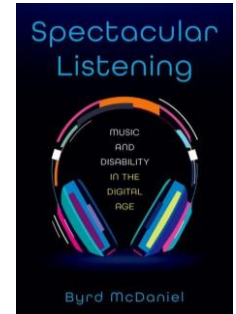
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BOOK REVIEW

Spectacular listening: Music and disability in the digital age (McDaniel)

Reviewed by David Limmer

Independent scholar, United Kingdom



Title: Spectacular listening: Music and disability in the digital age **Author:** Byrd McDaniel **Publication Year:** 2024 **Publisher:** Oxford University Press **Pages:** 216 **ISBN:** 9780197620465

REVIEWER BIOGRAPHY

David Limmer is a Scotland-based music therapist working with adults with sensory impairments and learning disabilities in Glasgow and Fife. David also has sensory impairments, mobility difficulties, and chronic and long-term health issues, and he has spoken about what his experiences as a disabled person bring to his work as a music therapist at the 12th European Music Therapy Conference, as part of training days for the British Association of Music Therapy, and to students studying on the Music Therapy MSc programme at Queen Margaret University in Edinburgh. [david_limmer@hotmail.com]

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Spectacular Listening: Music and Disability in the Digital Age is written by Byrd McDaniel, music researcher, ethnomusicologist, and Assistant Director of Student Development at Brown University in Alabama. Although the author is careful to emphasise his identity as straight, white, cisgendered, and non-disabled throughout the book, the warmth, clarity, and curiosity of his writing and the thoughtful retelling of the personal experiences of the disabled individuals interviewed in each chapter consistently demonstrate a nuanced understanding of the issues being explored, as well as his deeply empathic and supportive allyship.

The book opens with a vignette from the author's own life, describing the challenges of visiting his grandfather as he lay dying in a care home during the throes of the pandemic. The story highlights the frustrating restrictions placed upon the author and their family during this difficult time, the ingenuity and creativity that was needed to manage these limitations, and how listening together in new ways helped them to reconnect. These themes permeate *Spectacular Listening*: the complex, emotionally charged, and sometimes paradoxical nature of disability and ableism; the frustrating, suffocating sense of feeling limited by things beyond your control; and the resourcefulness and imagination needed to overcome accessibility challenges. All this deftly situates the book within the current discourse surrounding disability and ableism in a broad range of music listening practices and beyond.

The author introduces the concept of *spectacular listening* as a fully embodied experience or performance of how music and sound can affect an individual, and how people share these

experiences. This is placed in opposition to what is deemed “normal listening,” which has “(1) an emphasis on ear-based engagement and contemplation, (2) a concept of sound as a bounded object for critical analysis, and (3) a celebration of meaningful listening as capable of being written or described through words” (p. 9).

In addition to the introduction and conclusion, the book is divided into four chapters that demonstrate spectacular listening within four different contexts/communities: air guitar competitions, lip syncing on various online platforms, reaction videos to popular music on YouTube, and podcasts. Each chapter contains an introduction of each phenomenon placing it in context within the disabled/non-disabled paradigm and a description of the methods used by the author to explore each phenomenon, followed by case study exploration and conclusions.

Throughout each chapter, the author is careful to highlight the social and personal dissonance experienced by so many disabled individuals, and the inevitable contradictions that are often at the heart of their lived experiences: the sense of community that can come from being ostracised; the permanent yet contextual nature of disability; and the suppression of those with disabilities on social media juxtaposed against the importance of internet forums to raise awareness and provide vital resources. McDaniel explores other important themes including the idea of “patronizingly inspirational” (p.66) online content being used to exploit disabled experiences for ableist narratives or monetary gain. He also raises the ways in which long-term health issues must sometimes be hidden for self-protection whilst at other times disclosed, or even performed, to advocate for yourself and others to ensure the support that is needed is provided. As a disabled person, to see these topics being discussed at all is powerful enough, but to have them explored with such delicacy and openness is invigorating.

Throughout the book, McDaniel’s warm, thoughtful writing creates a rich tapestry from the many complex strands of these somewhat marginalised listening practices and the wider disabled community, ultimately highlighting the vibrant multiplicity of the subject at hand. But it is the bright, golden threads of personal experience woven into each chapter from the individuals being interviewed that really shine. They demonstrate not only the highly emotive nature of the topic being explored, but also the ingenuity and incredible insight of people that are so often marginalised and misunderstood by wider society. In a reaction video to Kodi Lee, an autistic and blind musician, disabled YouTuber “Daryl” rails against the inevitable narratives that sprang up after Lee’s TV performance, which posited disability as something that must be overcome to succeed. Instead, Daryl suggests:

[Kodi Lee] is not succeeding in spite of his disability. He is succeeding because of it. His disability has given him the gifts that he has today. He wouldn’t have those gifts without his blindness and without his Autism. (p. 107)

In another interview, disability activist Alice Wong tells of her own internalised ableism after working in radio for many years as she pushed back against notions that disabled voices aren’t as pleasing or engaging:

Two years ago, I needed to start using the Bi-Pap during most of the day...
As I attend meetings and events, I noticed a difference in the way people relate

to me. I have to repeat myself because people can't understand me. If a breath is coming in right in the middle of a speech, I have to pause, creating unnatural and awkward speech patterns... A big part of my identity, ego, and self-image is centered on my voice and writing. I had to confront my discomfort and accept my new sound and body that has become increasingly cyborg-like as time goes on. (p. 124)

Overall, *Spectacular Listening* achieves a difficult task, shining light on relatively new and under-explored listening practices while fearlessly yet sensitively exploring disabled experiences, with all their contradictions, their richness, and the strength and community that can be found by sharing your vulnerabilities and experiences with the world. As McDaniel states, "Accessibility implies someone being able to access another perspective or a conversation, and accessibility also implies someone giving oneself up to be accessed by others, through the act of sharing and revealing aspects of an interior experience" (p. 125).

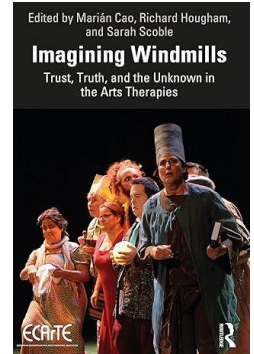
BOOK REVIEW

Imagining windmills: Trust, truth, and the unknown in the arts therapies (Cao, Hougham & Scoble, eds.)

Reviewed by Bridget Grant

Queen Margaret University, United Kingdom

Title: Imagining windmills: Trust, truth, and the unknown in the arts therapies **Editors:** Marián Cao, Richard Hougham & Sarah Scoble
Publication Year: 2022 **Publisher:** Routledge **Pages:** 250 **ISBN:** 9780367626693



REVIEWER BIOGRAPHY

Bridget Grant is an art psychotherapist and clinical supervisor living and working in Scotland. She has worked in many different contexts with a wide range of clients, maintaining a special interest in perinatal art therapy. She is a lecturer for the MSc Art Psychotherapy at Queen Margaret University and British Association of Art Therapists (BAAT) Scotland Committee representative for private practice. Bridget is particularly interested in how imagination, metaphor and the irreducible and ineffable aspects of the image in art therapy create opportunities to connect more deeply. [BGrant@qmu.ac.uk]

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Published in 2022, this edited collection of papers emerges from the bi-annual conference of the European Consortium for Arts Therapies Education (ECARTE) held in 2019. *Imagining Windmills: Trust, Truth and the Unknown in the Arts Therapies* reflects the conference's theme, inspired by Cervante's masterpiece, *Don Quixote*, first published in 1604 (Cervantes, 2000, p. xi). The question of finding truth within "imagination as a place of multiple realities" (Cao et al., preface) is the stuff arts therapies are made of and feels particularly relevant to the socio-cultural-political context in which the conference was conceived and the chapters written. The conference happened just before the COVID-19 pandemic, and authors refer to writing their chapters in the subsequent lockdowns when people were thrown from one reality into another. The flourish of innovative artistic projects appearing in the online space at that time, provided a means of expression and connection, suggesting imagination and creativity are what got many through. However, in the UK, the Government's declaration "we are all in this together" rang hollow as the pandemic revealed local and global inequalities, which could mean the difference between life and death. With the appearance of Orwellian like "alternative facts" (Herrmann, p. 32), it all began to feel a bit 'mad' and unknown as truth and trust seemed to unravel.

Global contributions from established arts therapists provide a cross-section of innovative philosophical approaches and clinical practice. The result is a rich multiplicity of explorations. As an art therapist myself, I am interested in how the ineffable qualities of images create opportunities to

connect more deeply. These themes highlight a fundamental part of what we do as arts therapists; being with the unknown within intersubjective realities. Staying with the unknowable and irreducible in any art form, within the therapeutic relationship, allows the unconscious to do its work and transformation to happen.

Marian Cao's opening chapter "On the Unknown that Art Addresses" carries a poetic drift. Informed by Foucault's notion of heterotopia, Cao uses three art works and a personal narrative to explore the theme. An eerie sense of the spaces we inhabited in lockdown resonates with the artworks where dwellings become strange, other-inner worlds and boundaries of time and place dissolve. Following this, Robert Romanyshyn highlights the mutuality between Quixote and his companion Sanches, symbolising contrasting aspects of the human psyche. Both are transformed and grow in relationship to the other. For Uwe Herrmann, the art materials and images she used with a young blind client held and offered exploration of changing truths, in a world which is increasingly polarised with reduced capacity for tolerating not knowing.

Dramatherapists Richard Houghman and Bryn Jones present their account of an experimental workshop designed to explore the process of constructing a social space using a strange environment and unconventional materials. Extending the invitation to make meaning, they wonder: where will the truth emerge? In contrast, Salvo Pituzzella's model, Dramatic Self Paradigm, seeks to identify and name the complex systems which inform the feeling of Self. Acknowledging these are fluid states of being, Pituzzella suggests dramatherapy may help to rework what is stuck or problematic. This embodied fluidity is also emphasised in Jean-Francois Jacques research into dramatherapy which frames aesthetic experience as an embodied way of knowing and locates the aesthetic within interpersonal interactions. His findings suggest the aesthetics of performance have a role in regulating interpersonal connections helping to effect change and insight.

Iris Bely's thought provoking chapter explores her work as a "secular Jewish art therapist" with "religious Muslim Arab" women patients in Israel (Bely, p. 105). Acknowledging the socio-political tensions, she states that her focus extends beyond polarised stereotypes to find a third, more nuanced space. Such spaces are vital as the recent events in Gaza and Israel show. Framing the work as intercultural art therapy, Bely considers issues of oppression for women and briefly mentions her client's perspective regarding the Jewish hegemony (Bely, p.112). However, given the context, and notwithstanding the time in which the chapter was written, bringing more of an intersectional lens might help to consider the power-dynamics at play and explore the deeper implications for transference and countertransference, not only in terms of different cultures, beliefs and the client's personal material, but also in relation to social identities and power structures (Talwar, 2022). I could not help but wonder, for example, how "the search for an inner home" (Bely, p.105) might link to issues of land and displacement. Continuing the subject of cultural consideration, Arts therapists Oihika Chakrabarti, Tripura Kashyap, Maitri Gopalakrishna and Nina Cherla (from the Netherlands) – trained in the West and working in India – make an important contribution to this book. Their decolonising, de-westernising stance is energising. Referencing processes of acculturation, they assert the need for professional arts therapies trainings to form within India, mitigating the replaying of colonial views when "transplanting" a Western, ethnocentrism training model and curriculum.

The sociopolitical focus continues as Anna Serrano Navarro, Tania Ugena Candel and Andrea Lopez Iglesias explore community-based art therapy with women in Madrid. Informed by feminist and community art therapy frameworks they engage women who may not access traditional psychological services. The richness of this research emerges in the findings; in the material that women shared in relation to their internal and external worlds.

Clinical innovation runs as a thread through the next chapters. Israeli dance movement therapists, Einat Shuper Engelhard and Maya Vulcan's fascinating work posits movement as a third language (alongside the verbal and emotional) within couple relationships. Their qualitative research found that communication through movement promoted trust when conflict arose verbally in couples. This finding resonates with music therapist Joy Gravestock's work with an adopted child with learning disabilities which is profoundly moving. In this impressive case study, Gravestock coins the term "micro moments of attunement" using countertransference and transference to understand her client's internal world. The courage and determination of both client and therapist are a powerful testament to the importance of psychoanalytically informed work with people with learning disabilities. Working as an art therapist with autistic children in the Netherlands, Caroline Schweizer moves beyond the intricacies of interpersonal dynamics and addresses the need for clarity regarding aims and treatment. Seeking to find a shared language to communicate with other involved parties, she presents a model incorporating Context, Outcomes, Art expression of the client and Therapist behaviour (COAT) as a way forward (Schweizer, 2022).

Sibylle Cseri's concluding chapter examines issues of trust in art therapy when working with adopted children. Her metaphor of a hermeneutic spiral helps to conceptualise the therapeutic process, and her case vignettes deepen our understanding of the transformative potential in aesthetic phenomena, held within the therapeutic relationship.

As rich as they are, the chapters are a lot to digest altogether, and the book feels a bit unwieldy. This reminds me of Don Quixote himself, and you could say the book's resistance to being neatly wrapped up or explained embodies this archetypal paradoxical character. A product of the 2019 ECARTe conference, *Imagining Windmills: Trust, Truth and Unknown in the Arts Therapies* is relevant for all arts therapists, whilst certain chapters will be of particular interest to certain modalities. It emerges in a time of significant historical sociocultural and political change; as I write, Donald Trump has just become the American President - for a second time. It feels increasingly important that the arts therapies continue to engage with the challenge of not-knowing, and trust "truth-as-unconcealing" as opposed to "truth-as-correctness" (McGilchrist, 2021. p. xvii). The diversely creative and imaginative contributions in this book offer the arts therapies a way forward in negotiating the territory of the unknown.

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