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EDITORIAL

Creativity and partnership

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While constraints often imply restrictions on freedom (Stokes, 2006), there are times when creativity thrives in the midst of (and is perhaps even inspired by) constraints. Limitations, pressures, and uncertainties can offer opportunities to creatively generate ideas and practices that are both novel and useful (Beghetto, 2019). Our common stance as music therapists is relational and improvisational. Spontaneity, flexibility, and creative responsiveness are baked into our practice and ways of being in the world. Experiences such as the Covid-19 pandemic challenged (and still challenge) us, particularly in light of managing the barriers that people and their communities may face when attempting to access music therapy services. As we have been living and musicking through a pandemic, we have needed a renewed sense of creativity to be able to adapt and respond to multiple and new kinds of constraints. As a form of problem-solving (Kupferberg, 2021; Treffinger et al., 2000), creativity is often a direct response to uncertainty. When we engage with, rather than dismiss uncertainty, ruptures in predictable patterns of living can offer openings with generous potential. Creative resolutions of limitations and uncertainty are emergent and dynamic (Beghetto & Karwowski, 2019).

Glăveanu (2013) proposes the five A's framework of creativity, focussing on an Actor (who brings their personal attributes to the process within a societal context); their Action (both psychological and behavioural); the Artifact that is created (within a cultural context of production and evaluation); an Audience (including collaborators, participants, opponents, colleagues, and so on); and Affordances (opportunities for action as we use what is created). Each element is interlinked. In the last few years, across music therapy services, training, supervision, continuing professional development and research initiatives, we have been prompted to examine anew how we engage as actors, the actions we can or need to take, how we create responsive services, tools, products, and spaces, how we can interact flexibly with clients, students, co-researchers and colleagues, and how we develop novel ways to build on the affordances of music therapy.

The current issue of Approaches celebrates the creative responses of music therapists and other related practitioners, tapping into all five "A's" of creativity across a range of contexts. In their report "*Thresholds: Skype supervision and the liminal within a 'journey of two',"* Maria Radoje and Sally Pestell offer insights to music therapy supervisors and supervisees who interact through online platforms. Predating the pandemic, their innovative online work mined the affordances of Guided Imagery and Music (GIM) based approaches to stimulate imaginative responses, thereby enhancing access to varying levels of consciousness. The report, "*Windows of student music therapy experience during COVID-19,"* written by Nuse, Meyer, Mattison, Smith, and McPhee, presents their experiences navigating their music therapy education during the pandemic in three different countries. Whilst facing "grief, loss, and lethargy," they also encountered "new-found energy and opportunities" (p. 23). Amy Clements-Cortés examines best practices for online conferences and education, focusing on the Online Conference for Music Therapy (OCMT). Clements-Cortés has participated in the OCMT each year since it began in 2011 and explains how virtual conferences bring benefits and challenges (such as keeping participants engaged, providing networking opportunities, accommodating diverse individuals and ensuring equitable access) that require ongoing creative solutions.

This issue also presents several reports that show creative approaches to music therapy practice. While GIM is typically offered in person, this has not always been possible during Covid-19. As a result, some GIM therapists have transitioned to providing online services, and a few have begun to explore creating self-care resources for particular client groups. Martin Lawes reports on "*Creating a COVID-19 Guided Imagery and Music (GIM) self-help resource for those with mild to moderate symptoms of the disease."* Lawes describes how he created an online resource that includes Pärt's *Spiegel im Spiegel* with a "talk-over," carefully taking into account the needs of Covid-19 patients, such as breathing difficulties. In their report "*Together in Sound: Music therapy groups for people with dementia and their companions – moving online in response to a pandemic*," Molyneux and colleagues reflect on how they could replicate many of the features of in-person sessions while transitioning to collaborative online group processes. Marianne Rizkallah writes about the development of the North London Music Therapy Phone Support Service for NHS staff during the COVID-19 pandemic, and reflects on the service's relevance for the music therapy profession. Furthermore, Lorraine McIntyre reports on adapting her practice during the Covid-19 pandemic, particularly in relation to running online music therapy sessions for trafficked women in a safehouse in England. McIntyre was required to rethink session structure, strategies of emotional containment, collaborations with other staff members, and communication approaches. In addition to the aforementioned publications that form a special feature dedicated to online music therapy, this issue includes an interview between Michael Bakan and Kenneth Aigen, a range of book reviews and three diverse articles by Cynthia Colwell, Mi hyang (Grace) Hwang and Leslie Bunt, and Enrico Curreri respectively.

The contents of the special feature, alongside other recent publications appearing in Approaches (e.g., Chandler & Maclean, 2022; Lotter et al., 2022), reflect the journal's engagements with the pandemic. Since 2020, we have been actively encouraging submissions by practitioners, researchers and students documenting and exploring the implications of the pandemic for music therapy, locally, nationally and internationally. As our ways of living with Covid-19 are changing over time, such publications offer valuable insights that feed into ongoing development of technology in music

therapy practice, supervision and education, explore ethical considerations, and point to new emerging practice and research approaches.

In closing, we are delighted to share some exciting news. Over the past months, we established a partnership between Approaches and Queen Margaret University (QMU) in Edinburgh. Building on the long-standing relationship of the university as a sponsor of Approaches and the shared values between the two organisations, QMU has become the official affiliated university and host of the journal. We warmly thank Brendan McCormack, Philippa Derrington, Fiona Coutts, Richard Butt, Barbara Burgess and other colleagues at QMU and at Edinburgh Diamond for this partnership which strengthens the infrastructure of Approaches and promotes open access publishing in the field. In 2023, the journal's website will change as we transition to an Open Journal System (OJS) platform. This development will be coupled by the development of new online resources and initiatives within Approaches.

REFERENCES

Beghetto, R. A. (2019). Structured uncertainty: How creativity thrives under constraints and uncertainty. In C. Mullen (Ed.), *Creativity under duress in education?* (pp. 27-40). Springer.

Beghetto, R. A., & Karwowski, M. (2019). Unfreezing creativity: A dynamic micro-longitudinal approach. In R. Beghetto & G. E. Corazza (Eds.), *Dynamic perspectives on creativity* (pp. 7-25). Springer.

Chandler, G., & Maclean, E. (2022). "There has probably never been a more important time to be a music therapist": Exploring how three music therapy practitioners working in adult mental health settings in the UK experienced the first year of the COVID-19 pandemic. *Approaches: An Interdisciplinary Journal of Music Therapy*, 1-26.

Glăveanu, V. P. (2013). Rewriting the language of creativity. The five A's framework. *Review of General Psychology, 17*(1), 69-81. https://doi.org/10.1037/a0029528

Kupferberg, F. (2021). *Constraints and creativity: In search of creativity science.* Cambridge University Press.

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. *Approaches: An Interdisciplinary Journal of Music Therapy*, 1-19.

Stokes, P. D. (2006). *Creativity from constraints: The psychology of breakthrough.* Springer.

Treffinger, D. J., Isaksen, S. G., & Dorval, K. B. (2000). *Creative problem solving: An introduction* (3rd ed.). Prufrock Press.

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ΣΗΜΕΙΩΜΑ ΣΥΝΤΑΞΗΣ

Δημιουργικότητα και συνεργασία

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Ενώ οι δεσμεύσεις συχνά συνεπάγονται περιορισμούς της ελευθερίας (Stokes, 2006), υπάρχουν περιπτώσεις όπου η δημιουργικότητα ευδοκιμεί εν μέσω δεσμεύσεων (και ίσως ακόμη εμπνέεται από αυτές). Οι περιορισμοί, οι πιέσεις και οι αβεβαιότητες μπορεί να προσφέρουν ευκαιρίες για τη δημιουργική ανάπτυξη ιδεών και πρακτικών που είναι τόσο καινοτόμες όσο και χρήσιμες (Beghetto, 2019). Η κοινή μας στάση ως μουσικοθεραπευτές είναι σχεσιακή και αυτοσχεδιαστική. Ο αυθορμητισμός, η ευελιξία και η δημιουργική αποκριτικότητα είναι ενσωματωμένες στην πρακτική μας και στους τρόπους ύπαρξής μας στον κόσμο. Εμπειρίες όπως αυτή της πανδημίας του Covid-19 διέγειρε (και εξακολουθεί να διεγείρει) προκλήσεις, ιδίως υπό το πρίσμα της διαχείρισης των εμποδίων που μπορεί να αντιμετωπίσουν τα άτομα και οι κοινότητές τους στην πρόσβαση υπηρεσιών μουσικοθεραπείας. Κατά τη διάρκεια της ζωής και της μουσικοτροπίας μας εν μέσω της πανδημίας, χρειαστήκαμε μια ανανεωμένη αίσθηση δημιουργικότητας για να μπορέσουμε να προσαρμοστούμε και να ανταποκριθούμε σε πολλαπλές και νέες δεσμεύσεις. Ως μορφή επίλυσης προβλημάτων (Kupferberg, 2021· Treffinger κ.α., 2000), η δημιουργικότητα είναι συχνά μια άμεση ανταπόκριση στην αβεβαιότητα. Όταν, αντί να απορρίπτουμε την αβεβαιότητα, εμπλεκόμαστε με αυτήν, οι ρήξεις των προβλέψιμων μοτίβων ζωής μπορούν να προσφέρουν ανοίγματα με πλούσιο δυναμικό. Οι δημιουργικές λύσεις των περιορισμών και της αβεβαιότητας είναι αναδυόμενες και δυναμικές (Beghetto & Karwowski, 2019).

Ο Glăveanu (2013) προτείνει το πλαίσιο των πέντε «A» της δημιουργικότητας, εστιάζοντας σε έναν Δρώντα (Actor) (ο οποίος φέρνει τα προσωπικά του γνωρίσματα στη διαδικασία εντός ενός κοινωνικού πλαισίου), στη Δράση (Action) του (τόσο ψυχολογική όσο και συμπεριφορική), στο Τέχνημα (Artifact) που δημιουργείται (εντός ενός πολιτισμικού πλαισίου παραγωγής και αξιολόγησης), στο Ακροατήριο (Audience) (συμπεριλαμβανομένων των συνεργατών, των συμμετεχόντων, των αντιπάλων, των συναδέλφων κ.ο.κ.) και στις Δυνατότητες (Affordances) (ευκαιρίες για δράση καθώς χρησιμοποιούμε ό,τι δημιουργείται). Κάθε στοιχείο είναι

αλληλένδετο. Τα τελευταία χρόνια, σε κάθε κατεύθυνση μουσικοθεραπευτικών υπηρεσιών, εκπαίδευσης, εποπτείας, συνεχιζόμενης επαγγελματικής ανάπτυξης και ερευνητικών πρωτοβουλιών, έχουμε κληθεί να εξετάσουμε εκ νέου το πώς εμπλεκόμαστε ως δρώντες, τις δράσεις που μπορούμε ή πρέπει να λάβουμε, τον τρόπο με τον οποίο διαμορφώνουμε ευέλικτες υπηρεσίες, εργαλεία, προϊόντα και χώρους, το πώς μπορούμε να αλληλοεπιδρούμε ευέλικτα με πελάτες, φοιτητές, συν-ερευνητές και συναδέλφους, και το πώς αναπτύσσουμε καινοφανείς τρόπους αξιοποίησης των δυνατοτήτων της μουσικοθεραπείας.

Το παρόν τεύχος του Approaches γιορτάζει τις δημιουργικές ανταποκρίσεις των μουσικοθεραπευτών και άλλων επαγγελματιών, αγγίζοντας και τα πέντε «Α» της δημιουργικότητας σε ένα εύρος πλαισίων. Στην αναφορά τους με τίτλο *«Όρια: Η εποπτεία μέσω Skype και το οριακό μέσα σε ένα 'ταξίδι για δύο'»,* οι Maria Radoje και Sally Pestell προσφέρουν ιδέες στους επόπτες και στους εποπτευόμενους μουσικοθεραπευτές που αλληλεπιδρούν μέσω διαδικτύου. Έχοντας προηγηθεί της πανδημίας, το καινοτόμο διαδικτυακό τους έργο αξιοποίησε τις δυνατότητες των προσεγγίσεων που βασίζονται στην Καθοδηγούμενη Νοερή Απεικόνιση και Μουσική (KNAM) για να διεγείρει φαντασιακές αντιδράσεις, αυξάνοντας με αυτό τον τρόπο την πρόσβαση σε διαφορετικά επίπεδα συνείδησης. Η αναφορά *«Παράθυρα εμπειρίας φοιτητριών μουσικοθεραπείας κατά τη διάρκεια του Covid-19»* των Nuse, Meyer, Mattison, Smith και McPhee, παρουσιάζει τις εμπειρίες των συγγραφέων σχετικά με τη μουσικοθεραπευτική τους εκπαίδευση κατά τη διάρκεια της πανδημίας σε τρεις διαφορετικές χώρες. Ενώ αντιμετώπισαν «θλίψη, απώλεια και λήθαργο», συνάντησαν επίσης «νέα ενέργεια και ευκαιρίες» (ελεύθερη μετάφραση, σ. 23). Η Amy Clements-Cortés εξετάζει τις βέλτιστες πρακτικές για συνέδρια και εκπαίδευση μέσω του διαδικτύου, εστιάζοντας στο Διαδικτυακό Συνέδριο για τη Μουσικοθεραπεία (Online Conference for Music Therapy, OCMT). Η Clements-Cortés έχει συμμετάσχει ετησίως στο OCMT από την έναρξή του το 2011, και εξηγεί πώς τα διαδικτυακά συνέδρια φέρουν οφέλη και προκλήσεις (όπως η διατήρηση της εμπλοκής των συμμετεχόντων, η παροχή ευκαιριών για επαγγελματικές γνωριμίες και δικτύωση, η εξυπηρέτηση διαφορετικών ατόμων και η εξασφάλιση ισότιμης πρόσβασης) που απαιτούν συνεχείς δημιουργικές λύσεις.

Αυτό το τεύχος παρουσιάζει επίσης διάφορες αναφορές οι οποίες καταδεικνύουν δημιουργικές προσεγγίσεις στη μουσικοθεραπευτική πράξη. Ενώ η KNAM τυπικά προσφέρεται δια ζώσης, αυτό δεν κατέστη πάντοτε εφικτό κατά τη διάρκεια του Covid-19. Ως αποτέλεσμα, ορισμένοι θεραπευτές KNAM έχουν μεταβεί στην παροχή υπηρεσιών μέσω διαδικτύου, και μερικοί έχουν αρχίσει να διερευνούν τη δημιουργία πόρων αυτοφροντίδας για συγκεκριμένες ομάδες πελατών. Ο Martin Lawes αναφέρεται στη δημιουργία ενός μέσου αυτοβοήθειας βάσει της μεθόδου KNAM για άτομα με ήπια ή μέτρια συμπτώματα της νόσου Covid-19. Ο Lawes περιγράφει πως δημιούργησε ένα ηλεκτρονικό μέσο που συμπεριλαμβάνει το έργο *Spiegel im Spiegel* του Pärt με ηχογραφημένη αφήγηση, λαμβάνοντας υπόψιν προσεκτικά τις ιδιαίτερες ανάγκες των ασθενών με Covid-19, όπως οι αναπνευστικές δυσκολίες. Στην αναφορά τους *«Μαζί στον Ήχο [Together in Sound]: Ομάδες μουσικοθεραπείας για άτομα με άνοια και τους συνοδούς τους – διαδικτυακή μεταφορά των συνεδρίων ως ανταπόκριση στην πανδημία»*, η Molyneux και οι συνάδελφοί της μελετούν τον τρόπο με τον οποίο θα μπορούσαν να αναπαράγουν πολλά από τα χαρακτηριστικά των δια ζώσης συνεδριών, μεταβαίνοντας παράλληλα σε συνεργατικές διαδικτυακές ομαδικές διαδικασίες. Η Marianne Rizkallah γράφει για την ανάπτυξη της τηλεφωνικής υπηρεσίας υποστήριξης του

North London Music Therapy για το προσωπικό της Εθνικής Υπηρεσίας Υγείας κατά τη διάρκεια της πανδημίας Covid-19, και αναλογίζεται τη σημασία της υπηρεσίας αυτής για το επάγγελμα της μουσικοθεραπείας. Ακόμη, η Lorraine McIntyre αναφέρεται στην προσαρμογή της πρακτικής της κατά τη διάρκεια της πανδημίας του Covid-19, ιδίως σε σχέση με τη διεξαγωγή διαδικτυακών συνεδριών μουσικοθεραπείας σε ένα καταφύγιο στην Αγγλία για γυναίκες που είχαν διασωθεί από κύκλωμα εμπορίας ανθρώπων. Η McIntyre κλήθηκε να αναδιαμορφώσει τη δομή των συνεδριών, τις στρατηγικές συναισθηματικής εμπερίεξης, τις συνεργασίες με άλλα μέλη του προσωπικού και τις επικοινωνιακές προσεγγίσεις. Εκτός από τις προαναφερθείσες δημοσιεύσεις που αποτελούν ένα ειδικό αφιέρωμα στη διαδικτυακή μουσικοθεραπεία, αυτό το τεύχος συμπεριλαμβάνει μια συνέντευξη μεταξύ των Michael Bakan και Kenneth Aigen, ένα εύρος βιβλιοκριτικών και τρία διαφορετικά άρθρα από την Cynthia Colwell, τους Hwang και Bunt, και τον Enrico Curreri.

Τα περιεχόμενα του ειδικού αφιερώματος, παράλληλα με άλλες πρόσφατες δημοσιεύσεις στο Approaches (π.χ. Chandler & Maclean, 2022· Lotter et al., 2022), αντικατοπτρίζουν την ανταπόκριση του περιοδικού στην πανδημία. Από το 2020, ενθαρρύνουμε ενεργά την υποβολή κειμένων από επαγγελματίες, ερευνητές και φοιτητές οι οποίοι καταγράφουν και διερευνούν τις επιπτώσεις της πανδημίας στην μουσικοθεραπεία, σε τοπικό, εθνικό και διεθνές επίπεδο. Καθώς οι τρόποι που ζούμε με το Covid-19 αλλάζουν με την πάροδο του χρόνου, τέτοιες δημοσιεύσεις προσφέρουν πολύτιμες γνώσεις που τροφοδοτούν τη συνεχή ανάπτυξη της τεχνολογίας στη μουσικοθεραπευτική πράξη, την εποπτεία και την εκπαίδευση, διερευνούν δεοντολογικούς προβληματισμούς και υποδεικνύουν νέες αναδυόμενες πρακτικές και ερευνητικές προσεγγίσεις.

Κλείνοντας, είμαστε στην ευχάριστη θέση να μοιραστούμε ορισμένα καλά νέα. Τους τελευταίους μήνες, συνάψαμε μια συνεργασία μεταξύ του Approaches και του Queen Margaret University (QMU) στο Εδιμβούργο. Βασιζόμενο στη μακροχρόνια σχέση του πανεπιστημίου ως χορηγού του Approaches και στις κοινές αξίες μεταξύ των δύο οργανισμών, το QMU αποτελεί πλέον το επίσημο συνεργαζόμενο πανεπιστήμιο και φορέα φιλοξενίας του περιοδικού. Ευχαριστούμε θερμά τους Brendan McCormack, Philippa Derrington, Fiona Coutts, Richard Butt, Barbara Burgess και άλλους συναδέλφους στο QMU και το Edinburgh Diamond για αυτήν την σύμπραξη που ενδυναμώνει την υποδομή του Approaches και προωθεί την πολιτική ανοικτής πρόσβασης στο πεδίο. Το 2023, ο ιστότοπος του περιοδικού θα αλλάξει καθώς θα μεταβούμε σε μια πλατφόρμα του λογισμικού Open Journal System (OJS). Η εξέλιξη αυτή θα συνδυαστεί με την ανάπτυξη νέων διαδικτυακών πόρων και πρωτοβουλιών εντός του Approaches.

ΒΙΒΛΙΟΓΡΑΦΙΑ

Beghetto, R. A. (2019). Structured uncertainty: How creativity thrives under constraints and uncertainty. Στο C. Mullen (Επιμ.), *Creativity under duress in education?* (σσ. 27-40). Springer.

Beghetto, R. A., & Karwowski, M. (2019). Unfreezing creativity: A dynamic micro-longitudinal approach. Στο R. Beghetto & G. E. Corazza (Επιμ.), *Dynamic perspectives on creativity* (σσ. 7-25). Springer.

Chandler, G., & Maclean, E. (2022). "There has probably never been a more important time to be a music therapist": Exploring how three music therapy practitioners working in adult mental health settings in the UK experienced the first year of the Covid-19 pandemic. *Approaches: An Interdisciplinary Journal of Music Therapy*, 1-26.

Glăveanu, V. P. (2013). Rewriting the language of creativity. The five A's framework. *Review of General Psychology, 17*(1), 69-81. https://doi.org/10.1037/a0029528

Kupferberg, F. (2021). *Constraints and creativity: In search of creativity science.* Cambridge University Press.

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. *Approaches: An Interdisciplinary Journal of Music Therapy*, 1-19.

Stokes, P. D. (2006). *Creativity from constraints: The psychology of breakthrough.* Springer.

Treffinger, D. J., Isaksen, S. G., & Dorval, K. B. (2000). *Creative problem solving: An introduction* (3η έκδοση). Prufrock Press.

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REPORT

Special Feature | Reports on online music therapy

Thresholds: Skype supervision and the liminal within a 'journey of two'

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ABSTRACT
In this report a trainee music therapy supervisor and a newly qualified supervisee explore their different perspectives of music therapy supervision within the context of what Amir (2001a) describes as a 'journey'. It is written as a series of reflections, aimed at stimulating discussion and awareness about liminal and intuitive processes through the writers' experiences of working in a virtual, dreaming space. Through examination of clinical material, transference and counter-transference processes, and acknowledgement of the symbolic, the writers detail how this liminality impacted the supervisory relationship, the clinical work, and the relationship to the training institution. The authors conclude with thoughts on how this enhanced their practice.

KEYWORDS
Skype,
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Guided Imagery and Music

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A NOTE ON THE LITERATURE

Until recently music therapists in the UK had no choice but to undertake supervision training designed for psychotherapists, due to the lack of training in music therapy supervision. This report documents the experiences and perspectives of a trainee supervisor on the first course in music therapy supervision in the UK, and a newly qualified supervisee, as they reflect on the process of supervision and the development of the relationship.

A literature review reveals a wealth of material on supervision from a psychotherapy or analytical perspective (e.g., The UK Balint Society, 2012; Cwick, 2006; Hawkins & Shohet, 2012), but much less has been written or researched on music therapy supervision. In 1984 Stephens wrote:

> The subject of supervision for the music therapist is becoming increasingly important in light of growing concern and interest in the music therapist's training and development after formal education is completed. The type of supervision most useful for music therapists is, therefore, important to address. (Stephens, 1984, p.1)

It would not be until Forinash published *Music Therapy Supervision* in 2001, that a book would become available addressing this issue through a variety of perspectives on clinical supervision, mainly by American authors (Forinash, 2001). It would be another 11 years before Odell-Miller and Richards (2012) would publish the only other textbook, *Supervision of Music Therapy,* which incorporates a variety of perspectives from the UK and Europe. More recently the music therapy community has begun to address the lack of individual articles on supervision, such as those written by Kang (2007) on peer supervision for GIM therapists, and Kim (2008), who explored the supervisee's experience in cross-cultural music therapy supervision. Edwards and Daveson (2004) discuss resistance and parallel processes in the supervisory relationship when supervising students, whilst Young and Aigen (2010) concentrate on supervising the supervisor, using live music to help identify parallel processes. Kennelly, Baker, Morgan and Daveson (2012), and Kennelly (2013) have focused on music therapy supervision and research on supervision, in Australia. The authors of this report hope to add to this growing body of work, through their reflections on the process of Skype supervision which took place within the UK.

The writing of this report was a collaborative effort, undertaken by email exchanges through which ideas were discussed and developed. Originally given as a presentation at the 2018 British Association for Music Therapy conference in London, and at Anglia Ruskin University's Supervisor's Placement Training day in the same year, it details how meeting through Skype affected the development of the supervisory relationship, and the relationship to the client's material. It draws on two case examples to illustrate the process.

The ideas presented in this report may be of interest to music therapy supervisors and supervisees, but also those of any discipline who find themselves working in a liminal space using Skype, Zoom or similar applications and software. As video and audio technology is becoming increasingly relevant in the therapeutic field, particularly for those who are geographically isolated, the authors hope this report may encourage consideration of the ways it can affect, enhance or influence the supervisory relationship. [1] The material which follows describes the supervisory journey from the individual perspectives of each author.

[1] Vigilance is required regarding confidentiality as some platforms, such as Skype, are now considered less secure than at the time the supervisions took place.

BACKGROUND

Maria (supervisor): I qualified from Roehampton with a Postgraduate Degree in 1999 and have worked in a variety of settings, specialising in adults with learning disabilities and older adults living with dementia. When I saw the University of the West of England (UWE), were offering a progress route to a therapeutic, rather than a research MA, in 2016 I eagerly pursued this opportunity to upgrade my qualification, mainly because they were offering a 30 credit module on music therapy supervision, which was the first training of its kind in the UK. I was also able to study Guided Imagery and Music (GIM) and Evidence Work Based Learning to complete the MA.

The supervision course consisted of eight monthly meetings in which there were seminars and papers on various approaches to supervision; these included the Balint (The UK Balint Society, 2012) and 7 Eyed Models (Hawkins & Shohet, 2012). There was a strong emphasis on the creative, for instance, using small objects (known as spectrogram) to create relational patterns or explore projections, thoughts or feelings about the client. We also worked with images, creative writing, and music listening and mandala drawing, as in GIM. We improvised together to explore the triadic relationship of client, therapist and supervisor, and also used a method of group supervision developed by music therapist Heidi Ahonen Eerikainen (2003), in which each therapist musically enacts an aspect of the client / therapist relationship. Additionally, we met in small groups each month for supervision of our own supervision.

Sally (supervisee): After a long career, teaching children, I embarked on a Music Therapy MA at UWE in 2012. The course was challenging and life-changing and when I graduated it felt like a completely new beginning for me. However, living in a rural community in Cornwall with no practising music therapists or supervisors nearby made me feel isolated, and trying to find work was difficult. I missed the support that studying at UWE had given me and the only feature of continuity was my work in a dementia care home where I had set up my final placement.

When the opportunity arose in May 2016, of studying GIM Level 1 back at UWE, I took it eagerly. This is where I met Maria and by the end of that week not only had the horizons of GIM been opened up to me, but I had found myself a supervisor! Although we lived 300 miles apart, I agreed to be the supervisee for Maria's training, and she was happy to be my supervisor.

THE 'JOURNEY OF TWO'

> Supervision is a journey of two, it is like an improvised song: it creates itself in the here and now, out of material from the past. It starts from a specific title, word, or sentence, and travels to the unknown, that is based on the known. (Amir, 2001a, p.210)

Sally: Looking back now Maria and I can clearly see the influence that GIM had on the supervisory process. Through receptive listening, GIM accesses the imagination and encourages creative responses to effect change. This process had started subconsciously within us during the Level 1 training. (Primary trainer Leslie Bunt offers three levels of GIM training, three being the most advanced,

which on completion, leads to a Fellowship of the Association for Music and Imagery). By listening to music in different ways we were becoming aware of the many levels of consciousness and our own personal responses, which we shared together when appropriate. This was the genesis of our way of working together, our earlier, shared experience.

Maria: As mentioned already, the supervision training at UWE incorporated many creative approaches to help us explore and get below the surface of the supervisee's and client's experience, supporting us to connect with unconscious or subconscious processes. For example, the mandala shown in Image 1 was drawn whilst exploring the beginning of the relationship, as part of a music listening process.

Image 1: Mandala reflecting the beginning of the supervisory relationship (Radoje, 2017)

It was a natural progression for me to consider paying attention to my dreams since I have always dreamed vividly, and think it is important to listen when dreams regarding my work surface. There were two dreams which were relevant to this supervisory process, and at an appropriate point, I decided to risk sharing them with Sally, though I was unsure how they would be received, and the impact they might have on her and her work. Additionally dreams have never in my experience, been discussed within music therapy trainings, and rarely appear in music therapy literature, so I wondered how ethical or appropriate it may be to share what I saw as a personal processing of the material, however relevant it was to the case. Later in the report Sally and I will reflect on how the dreams impacted on the supervision, but prior to this we will touch on how music therapists access supervision within the UK, the setting up of the supervisory contract, and why meeting by Skype may become one of the few options open for some therapists.

In 2016, a supervision interest group was set up for the first time through the British Association for Music Therapy and a survey undertaken by Rickwood (2017) revealed some interesting points about how practitioners access supervision:

- 10% of the 40 supervisors who answered, offered Skype supervision.

- When asked how they chose a supervisor, the majority of respondents chose someone who was geographically near to them, had experience in their field, or had been recommended, with geographical nearness being the most important component overall.

Sally: As geographical proximity is a major consideration for most supervisees, there are several advantages and disadvantages to using Skype. Both people are in their own environment and there is an economic advantage regarding the time spent travelling and the costs involved. Skype can bring people together who may not have a supervisor living near them e.g., rural parts of the UK and parts of the world where there are few other music therapists. Whatever the situation, Skype widens the choice for all. Some disadvantages may centre on technology. For instance, it is difficult to make music about the client when not in the same room with each other and there are potential issues with confidentiality and security when sharing recordings. Maybe the main disadvantages are to do with the different kinds of reality that I think are created. Not being in the same room can be seen as a barrier to connectedness because it is harder to 'read' the other person to pick up on those non-verbal cues, and there can be a distinct lack of flow if there is a technical problem. These factors could possibly impede the development of the relationship, though conversely, for some populations this could be an advantage. Baker and Krout (2009), for instance, found that distance was actually helpful in therapeutic song writing sessions with a young man on the autistic spectrum, who presented as more confident and engaged than during face to face sessions.

Maria: It is also important when establishing the supervisory relationship to reflect on the boundaries or supervisory contract prior to starting supervision, and Sally and I spent some time thinking about what might be useful and relevant for our method of working. As we were not able to meet in the same space, we considered having additional contact outside of the Skype supervision, by email or phone to facilitate the working relationship if necessary.

Reflecting on the wider profession, it can be helpful to consider how music therapists establish these boundaries at the outset of supervision, whether or not to use verbal or written contracts, and to think about how different theoretical perspectives may be explored and integrated into the supervision. Additionally, time/place/frequency all have to be negotiated. Setting boundaries helps manage expectations of what can and can't be met in supervision, and what may be more appropriately taken to personal therapy. Many music therapists also supervise students. Careful consideration needs to be given to how much time can be spent with students in the clinical day, and the boundaries of the supervision, given there will be communication with the university. Students may also be under pressure to achieve academically which can impact the supervisory space.

In 'Supervision in Context: a balancing act,' music therapist Sandra Brown quotes Crick, a psychotherapy trainee, on the student's experience of supervision, as being in "an adolescent position in relation to the training, the pains of learning and the discomforts of being assessed" (Brown, 2009 pp. 122). Brown continues:

> Many music therapy students are professionals in their own right and have a personal identity related to (and often dependent on) their previous musical skills and experience. Having to come to terms with the 'deskilling' of one's

> music use, and with the 'not knowing' of the therapy process […] can be an enormously painful and vulnerable experience. Inevitably having to further expose oneself in supervision, with the implication of judgement and control of the authority figure and the actuality of the ongoing assessment, causes the student therapist enormous anxiety, insecurity and often resentment and anger as the basis on which s/he has built his/her self-esteem and identity no longer seems valued or even in view. (Brown, 2009, pp.122-124)

This reminds me of my own experience of being a student again at the start of this particular supervisory journey, and how receiving supervision of my own work also provoked some anxiety in me. Sally and I had begun establishing our supervisory relationship and had met twice by Skype, when she was approached about working with a boy who was struggling at school. This made me wonder if I would manage to be a 'good enough' supervisor, and I was mindful of the university's expectations of me to develop and to meet their criteria, with the implication of course, of judgement.

Sally: In November 2016 I started working with a 12-year-old boy on the autistic spectrum who was finding the transition from Key Stage 2 to Key Stage 3 a real challenge. When I first met K (a pseudonym), he was attending school for just over an hour every morning because he was struggling to cope with mainstream education due to high levels of anxiety. There were serious concerns about his social, mental and emotional health, both from the parents and school.

When asked, K was unable to identify any positives about himself and school except that he knew he was good at music. The situation was at crisis point. This is where music therapy helped K to cope. I saw him at home for the first session, then he agreed to go back into school for the music therapy sessions only. His improvisations were short and repetitive, showing no change in dynamics, with only a slight quickening pulse. However, I believe he found them comforting, empowering and regulating. He became aware that I was listening to him in a safe space. He began to take risks in the music, chose different instruments and explored different rhythms. He stayed with the process and soon began to tell me what he did and did not like about our sessions. K made his own choices and was being listened to.

Maria: Prior to our third supervision session, Sally emailed me to let me know the focus of the supervision would be K and described how the school had said that music therapy was their 'last hope.' As the Skype session started Sally suddenly turned the computer round and I found myself looking at a beautiful winter landscape, the one in which the music therapy took place, and is so different to the cityscape in which I live and work. This sharing represented a deepening of trust in the supervisory relationship for me, and also something about grounding in the physical space, which would have been automatic if we had been meeting in person. It was an invitation to connect with Sally and K in this landscape, and it allowed me to risk sharing something of my own, a dream I'd had that morning about Sally's work:

> Sally called a conference of professionals involved in K's case; initially we were the only two sat around a large oval table but eventually everyone turned up in time for the meeting.

Although it could be seen as a compensatory dream, possibly conveying something about the feelings of isolation and of being alone with this sensitive and difficult work, it was also very reassuring to know that the necessary professional skills would be available to us, that they would 'turn up'. It helped me to have confidence in my ability to think about this client and to support Sally's capacity to do so too. This was necessary, particularly when Sally talked about the amount of music therapy per week that was being proposed by the school, and I instantly developed a headache and felt nauseous. Staying with this counter-transference and listening to these feelings helped me to reflect on the proposals with her, and enabled us to think more deeply about K's issues and the pressures from the school. Bringing this into my supervision at UWE was containing for me, and also gave me a greater sense of security, which was helpful, as K presented with some risky behaviours which needed to be held very carefully by Sally, myself and the other professionals involved in this work.

Sally: I remember this supervision session with Maria well. I was feeling the need to connect more with her before starting this work, and there I was looking at a screen not knowing how to do it! Our relationship was in the early stages and I was thinking about how it must be for her in London, working in such a different landscape from mine. It was a beautiful morning outside, the sun was shining, there had been a really hard frost the night before and I wanted to share this with Maria, because it sparked such a positive feeling in me, and I hoped I could give her that feeling too. I was amazed when she then related her dream to me. If I had not spontaneously turned my computer around this might have been unspoken and this connection unmade, which gave me confidence in my intuition. Subconsciously perhaps, there could also have been a parallel with K's need to step into a different space or landscape to work through things, with the development of the supervisory relationship. I believe K had a need to open that 'wardrobe door' from his safe, secure home base and enter a 'Narnia-like' world where he could explore a different landscape full of new sensory experiences. In the Skype space, myself and Maria were also discovering new territory, and learning to access our inner landscapes in ways we might not if we had been in the same room. As K explored his new territory, he was able to develop a positive relationship with someone whom he trusted would not judge him, as there was no 'right or wrong;' he could accept invitations to play and take risks, knowing that he could return 'home' whenever he wished. As K often ran out of classrooms in a distressed state during lessons, I was very careful to arrange the room with a clear exit route for him knowing there was a teaching assistant sitting in the corridor outside should this happen. I also asked him if he would like the door open or closed. He said he preferred it to be closed. K never ran out of any music therapy session and he was always the one to open and close the door behind him.

To conclude this particular case, as a result of music therapy, K was able to return to school for specific activities, and after 24 sessions was able to be there on a regular basis. Our work together seemed to be the necessary bridge to carry him safely and positively into the next stage of his life, and supervision helped contain some of the expectations and pressures from the wider team.

Maria: Reflecting more deeply on the idea of Skype creating a new or different kind of reality, it is possible to think of it in terms of a threshold:

> A threshold is […] a place where it is possible to make connections between the past, present and future. A threshold leads from outside to inside; it is a literal and symbolic place between different worlds; it is an image pregnant with anticipation, mystery and not without some superstition. A threshold can also be a doorway or gateway to new understanding and awareness […] The Roman god Janus was the first god of all doorways […] he was represented as looking in different directions simultaneously with a double-faced head. He could observe both the entrances and exits of public buildings and the interiors and exteriors of private houses. He was the god of beginnings and endings, of representing transitions between outside and inside, between the worlds of the country and the city. (Bunt & Hoskyns, 2002, pp.2-3)

Sally: Meeting in the Skype space, we found ourselves working in three places at once, two physical, one virtual. The virtual acted as a threshold or liminal space where at times other layers of consciousness were experienced, like those in GIM. For instance, we both became more aware of our own contrasting geographical settings and personal thresholds about two months into the work; I was just starting my music therapy work whereas Maria had many years of experience, but there was also a shared sense of standing on the edge, looking outwards towards new horizons in our own personal development as music therapists. To illustrate this development, we will share a second case example, which involves my work with people who have advanced dementia and live in a care home that adopts a person-centred approach. The home belongs to an organisation which believes that feelings matter most and that if we can identify those feelings by the behaviours that are presented, we can begin to understand the place that dementia brings people to, improve their quality of life, and create meaningful moments for them.

At the home, every effort is made to make the residents feel they are part of a loving family. The staff team never wear uniforms, they eat together with the residents and their visiting relatives, meals are always freshly prepared including vegetables and produce from the garden, and residents are encouraged to make their own decisions about how and where they spend their time. There are no locked doors (just a discreet alarm system), residents are encouraged to spend as much time as they like in the garden and help with household chores e.g. hanging the washing out, bringing it in, folding it, washing up, and other helpful jobs in the kitchen. Local schoolchildren come and read to them, donkeys visit with an ice cream van and there are visits in small groups to the seaside, memory cafes and local events. When one of the young staff got married, some residents went along too!

I hold a weekly open music therapy group with people whose ages range from 68 -95 years, and so the music we use covers quite a few decades. All the staff work in the 'present moment', concentrating our efforts on what each person can still do and embracing every emotion that arises. Individual sessions are held in resident's rooms where they are amongst their own belongings and feel safe. I tailor the work more closely to their specific needs, which depends on the kind of dementia they have and how advanced it is. I also see my role as being alongside these clients as their dementia progresses, supported by the home which recognises the importance of addressing the psychological needs advocated by Tom Kitwood (1997); attachment, inclusion, identity, occupation, comfort and love.

As Maria and I reflected together on the writing of this paper, we also made a link between the double-headed god, Janus (Image 2) and the clients, in the sense that they were inevitably closer to the end of their lives and facing a different journey ahead, whilst also still being connected with some memories and parts of their identities from their past, all of which I brought into the Skype space.

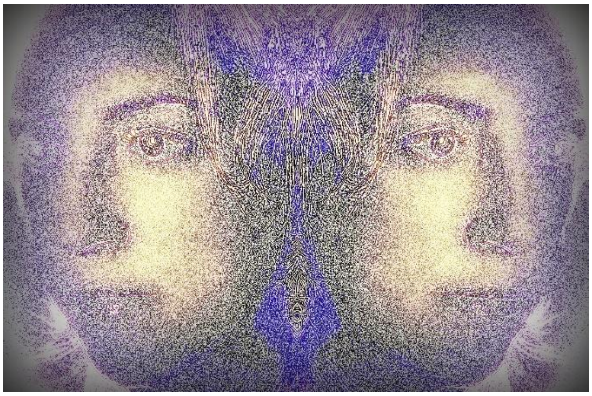

Image 2: Janus, Goddess of the Liminal (Radoje, 2020)

Maria: For me, the fourth supervision session clarified this link with the client's unconscious / conscious material, how it interconnected with mine and Sally's levels of consciousness, and the way that Skype may have amplified the liminal. Before the start of this supervision I began to think about how I could 'get into the space' to be with Sally, and I found myself lighting all the candles in the room I would be working in, at the same time asking myself '*Maria, what are you doing*?' Although I did not know, I trusted it, and as the supervision unfolded, I began to understand, as Sally talked about the death of four residents at the care home over the Christmas period.

During the supervision it was hard for us to process this material, not only was it painful for us to think about, but I also had a sense from our discussion, that there was a transference from the wider staff team, who may also have found it difficult and painful to acknowledge what had happened. In my work with older adults in continuing care, it has been a sad fact that over the winter months there is an increased risk of illness amongst residents and usually more deaths than at other times of the year. On returning after a break, strong feelings of emptiness and loss can be present, though there are not always the spaces to acknowledge these feelings. Part of the difficulty in making space, is that rooms are usually filled fairly quickly by the living, and that care has to continue. I tried to use these experiences to help Sally think about the dynamics in the home, and to find ways of making space so that the resident's lives could be remembered. I was also very aware of a strong urge in me to be able to create some music or listen to something to help us process the passing of these four souls, but this would have meant leaving the screen and abandoning Sally at this crucial point, in order to get my cello or find something suitable. However, at the end of the supervision I told her about lighting the candles.

Sally: My own personal experience of the Skype sessions up to this point was mixed. Although I greatly appreciated Maria's help and guidance I found the medium of Skype uncomfortable because it felt impersonal. I was beginning to see it as a barrier and at times I realised I even hid behind it. This seemed to be reflected in my work with the residents. I had been working at the home for over two

years, knew the place well, supported the ethos and enjoyed good relationships with both staff and residents. However, a fine line exists between life and death, as well as a feeling of unpredictability, with sometimes sudden changes in residents and their families, which can impact on staff. When someone dies it hits hard, because it is like losing a member of the family.

Over the period of Christmas and New Year, four out of the total 16 residents died and I realised that I had become very removed from processing this fact. I carried on as usual, feeling very little, and when we had our next session, I remember communicating this to Maria in a relatively detached way. This time of the year also resonated with a personal, family bereavement. Then Maria told me that before the session she had lit candles, knowing nothing of what I was going to say to her. This action was the catalyst that 'unfroze' me as the barriers came down and other layers of consciousness could then come into play.

Maria: The next morning after the supervision, I had a dream involving Elgar's music:

> I was in a rehearsal room with a choir somewhere who were rehearsing the Dream of Gerontius by Elgar. The conductor was my friend and when one of the altos dropped out, I was asked to take her role. She had a solo.

In his introduction to *Symbol and the Symbolic* by Schwaller de Lubicz (Egyptologist and explorer of consciousness), his translator Robert Lawlor suggests:

> A method of viewing is required comparable to our hearing faculty: one must learn to listen to the symbolic image, allowing it to enter into and pervade one's consciousness, as would a musical tone which directly resonates with the inner being, unimpeded by the surface mentality. In this moment of inner identity between the intellect and the aspect of the tangible world evoked by the symbol, we have the opportunity to live this knowledge. (Lawlor, 1981, p.11)

The symbolism of this dream reminded me what it is like to work in a place where death is constantly being rehearsed, the impact on those involved, and how difficult it can be to stay with these losses in our professional work. My dreaming self had also compensated for the lack of music and the strong urge I'd had to use it to acknowledge the transition of those four souls, or take the 'solo' role. However I did not have any conscious knowledge of the background to Elgar's work, so I had to do an online search to find out what my unconscious already knew! I discovered the story is about an elderly soul transitioning to the afterlife who is guided by Angel, the role sung by the alto. I was astonished to find that some part of me had chosen something with such resonance, and it helped me a great deal in digesting this supervision session, the dynamics of the supervisory relationship, and what was happening within the home. Bringing this into my own supervision at UWE provided a further opportunity for reflection on this work, and deepened my understanding of its message.

Sally: I was moved when Maria related this dream to me and from then on I knew consciously that it was ok to be more creatively connected in my work and our supervision sessions together. Reflecting on the impact of the integration of 'concept and intuition' (John, 2009), it seemed as if I was

compartmentalising them until supervision facilitated the expansion of something, some inner growth in me as a music therapist. As previously stated, Maria and I live in contrasting locations and this made me suddenly look at the geographical features around me with more awareness; not least the branch railway line, upper reaches of a river and a canal that I cross every time I visit the care home, even having to phone up and ask permission to cross first! These became symbolic for me as did all the landscapes that I found myself in, during work and also in my personal life. Bridges, rivers, pathways, the sea, the moors, water, air, fire, earth, shapes, patterns, colours… I became so much more aware of everything and how we connect, and I realised that my personal growth and my growth as a music therapist could closely influence each other to positive affect, and most importantly help me to do the best I could for the clients I work with. The mandala below (Image 3) was drawn reflecting back on the journey we had travelled together during supervision. The candle flame is a symbol for breaking through a barrier and illuminating other layers of consciousness.

Image 3: Mandala reflecting on the supervision journey (Pestell, 2017)

Maria:

> It is thinking that makes use of concept and intuition. Dreaming and art-making are creative processes that can strongly manifest this capacity of mind […] The optimising of the dynamic relation between concept and intuition is the hallmark of the evolving therapist, the therapist's reflective processes, which, if held in the right dynamic tension, become the single most potent factor in the healthy working of the therapist. (John, 2009, pp.98-99)

This quote by music therapist David John, could equally apply to the supervisor. During my training as I began to feel more at home with new theoretical concepts, I developed more trust in my intuitive, creative, dreaming self. I believe this is a crucial aspect of who we are as musicians, therapists and supervisors, and can sometimes be overlooked in the striving to measure, achieve, and evidence our work. Integrating these aspects of ourselves helps us discover the ideal 'dynamic tension' suggested by John and facilitates the expansion of the inner worlds of therapist and supervisor. Dorit Amir (2001b, p. 209) says: "I am not only looking at meaning from just my cognitive mind. Meaning comes from other realms within me that have wisdom, and they tell me something in an intuitive way through an insight."

CONCLUSION

To conclude with some final reflections on the supervisory journey; supervision invites us, like Janus (see Image 2 above), to experience and explore the interface between our inner and outer worlds, and those of our clients. Cox (1978, p. 239) writes that: "mutuality is needed […] where both supervisee and supervisor can dare to risk the exposure of […] feelings". Undertaking this journey of learning together, this supervisor and supervisee also dared to risk the exposure of external and internal landscapes, and the interface of their physical and dream worlds. The initial meeting in the GIM space facilitated this opening, and Skype amplified the experience by acting as a threshold, one in which other layers of consciousness became more evident, helping connect to those spaces in the clients. Amir compares the experience of making this journey together, to a musical improvisation, one which takes us from the familiar, to the completely unexpected - "a journey of two" (Amir, 2001a, p. 210).

REFERENCES

Ahonen-Eerikainen, H. (2003). Using group–analytic supervision approach when supervising music therapists. *Nordic Journal of Music Therapy*, *12*(2), 173-182.

Amir, D. (2001a). The journey of two: Supervision for the new music therapist working in an educational setting. In M. Forinash (Ed.), *Music therapy supervision* (pp. 195-210). Phoenixville, PA: Barcelona Publishers.

Amir, D. (2001b). Layers of meaning. *Nordic Journal of Music Therapy*, *10*(2), 209-220.

Baker, F., & Krout, R. (2009). Songwriting via Skype: An online music therapy intervention to enhance social skills in an adolescent diagnosed with Asperger's Syndrome. *British Journal of Music Therapy*, *23*(2), 3-14.

Brown, S. (2009). Supervision in context: A balancing act. In H. Odell Miller & E. Richards, (Eds.), *Supervision of music therapy* (pp. 122-124). London: Routledge.

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

Cox, M. (1978). *Structuring the therapeutic process: Compromise with chaos* (1st ed.). Oxford: Pergamon.

Cwik, A. J. (2006). The art of the tincture: Analytical supervision. *Journal of Analytical Psychology*, *51*(2), 209-225.

Edwards, J., & Daveson, B. A. (2004). Music therapy student supervision: Considering aspects of resistance and parallel processes in the supervisory relationship with students in final clinical placement. *The Arts in Psychotherapy, 31*(2), 67-76.

Forinash, M. (Ed.). (2001). *Music therapy supervision.* Phoenixville, PA: Barcelona Publishers.

Hawkins, P., & Shohet, R. (2012). *Supervision in the helping professions* (4th ed.). Milton Keynes: Open University Press.

John, D. (2009). Getting better: Some thoughts on the growth of the therapist. In H. Odell-Miller & E. Richards (Eds.), *Music therapy supervision* (pp. 98-99). Hove: Routledge.

Kang, H. J. (2007). *Peer group supervision for Korean music therapists with Guided Imagery and Music (GIM)* (Master's thesis). Retrieved from ProQuest Dissertations and Theses Database (UMI No. 1448485).

Kennelly, J. (2013). *Sights, sounds and feelings: The views, experiences and practices regarding professional supervision for Australian-based music therapists*. Doctoral dissertation, School of Music, The University of Queensland, Australia. Retrieved from https://espace.library.uq.edu.au/view/UQ:319389

Kennelly, J., Baker, F. A., Morgan, K., & Daveson, B. A. (2012). Supervision for music therapists: An Australian cross-sectional survey regarding views and practices. *Australian Journal of Music Therapy, 23*, 41–57.

Kim, S. (2008). The supervisee's experience in cross-cultural music therapy supervision. In A. Meadows (Ed.), *Qualitative inquiries in music therapy* (vol. 4, pp. 1–44). Gilsum, NH: Barcelona Publishers.

Kitwood, T. (1997). *Dementia reconsidered*. Milton Keynes: Open University Press.

Lawlor, R. (1981). Translator's preface. In R.A. Schwaller de Lubicz, *Symbol and the symbolic ancient Egypt, science, and the evolution of consciousness* (p. 11). Rochester Vermont: Inner Traditions International.

Odell-Miller, H., & Richards E. (Eds.). (2012). *Supervision of music therapy*. New York, NY: Routledge.

Pestell, S. (2017). *Mandala* (pencil and chalk pastel on paper). Cornwall: Private Collection.

Radoje, M. (2017). *Mandala* (pencil and oil pastel on paper). London: Private Collection.

Radoje, M. (2020). *Janus, Goddess of the Liminal* [colourised photo]. London; used with permission.

Rickwood, J, (2017). *Survey on the supervision of music therapy,* UK BAMT Network Publication.

Stephens, G. (1984). Group supervision in music therapy. *Music Therapy, 4*(1), 29–38.

The UK Balint Society (2012). About Balint Groups. Retrieved from https://balint.co.uk/about

Young, L., & Aigen, K. (2010). Supervising the supervisor: The use of live music and identification of parallel processes. *The Arts in Psychotherapy, 37*, 125–134.

Ελληνική περίληψη | Greek abstract

Όρια: Η εποπτεία μέσω Skype και το οριακό μέσα σε ένα «ταξίδι για δύο»

Maria Radoje | Sally Pestell

ΠΕΡΙΛΗΨΗ

Σε αυτή την αναφορά, μια ασκούμενη επόπτρια μουσικοθεραπείας και μια προσφάτως καταρτισμένη εποπτευόμενη εξερευνούν τις διαφορετικές προοπτικές τους σχετικά με την εποπτεία της μουσικοθεραπείας μέσα στο πλαίσιο που η Amir (2001a) περιγράφει ως «ταξίδι». Αυτό αποδίδεται ως μια σειρά αναστοχασμών, οι οποίοι αποσκοπούν στο να διεγείρουν συζήτηση και στην ευαισθητοποίηση σχετικά με το οριακό [liminal] και τις διαισθητικές διαδικασίες, μέσω των εμπειριών που αποκόμισαν οι ίδιες οι συγγραφείς δουλεύοντας σε έναν εικονικό, ονειρικό χώρο [dreaming space]. Μέσω της εξέτασης κλινικού υλικού, των διαδικασιών μεταβίβασης και αντιμεταβίβασης, αλλά και της αναγνώρισης του συμβολικού, οι συγγραφείς αναλύουν τον τρόπο με τον οποίο επηρέασε αυτή η οριακότητα [liminality] την εποπτική σχέση, το κλινικό έργο και τη σχέση με τον εκπαιδευτικό οργανισμό. Οι συγγραφείς καταλήγουν με σκέψεις για το πώς τα παραπάνω ενίσχυσαν την πρακτική τους.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

Skype, εποπτεία, άνοια, μουσικοθεραπεία, Καθοδηγούμενη Απεικόνιση και Μουσική [Guided Imagery and Music]

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REPORT

Special Feature | Reports on online music therapy

Windows of student music therapy experience during COVID-19

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ABSTRACT

The COVID-19 pandemic has had adverse effects on many individuals. This report aims to explore the impact this pandemic has had on the lives of five music therapy students. Three students from South Africa, one from Scotland, and one from New Zealand came together to write about their experiences of studying music therapy during this global outbreak. Each student shared their responses to three broad questions through writing essays and offering non-verbal creative responses. The report ends with a reflection which ties the individual contributions together and includes a synopsis of the concerns they share as music therapy students entering into the profession during the COVID-19 pandemic.

KEYWORDS

student perspective,
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music therapy

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INTRODUCTION

When COVID-19 became a global pandemic in the early months of 2020, music therapy students worldwide found themselves in the midst of an extraordinary shared experience. With clinical placements and thesis-writing well underway, student clinicians were suddenly forced to end their face-to-face contact with clients and classmates and isolate alongside the rest of the world. Suddenly, the requirements of training and education, expectations for learning, access to valuable social resources, and the overall sense of purpose that accompanies the work of a music therapist was enormously challenged. The global pandemic brought with it experiences of isolation and sequestering, but also a greater context of togetherness, connection, and collective being. We are five music therapy students from different courses across the world – Nethaniëlle, Cara, and Karin in South Africa; Liana in Scotland; and Holly in New Zealand. Each of us have contributed individual responses to this article, while Cara and Holly volunteered to write the introduction and Liana volunteered to write the final reflection and conclusion.

Encouraged by our lecturers, in July 2020, we came together to describe our experiences of COVID-19 for *Approaches*, from the perspective of music therapy students and recent graduates (Liana and Holly graduated during the writing of this report). This report is a curation of descriptions of our individual experiences, where we recount our unique circumstances and situations with the aim of making sense of them within the greater context of a moment in time we all experienced. After many Zoom meetings of sharing our stories with each other, we decided on a structure of three questions for group members to answer individually.

The three questions we answered were:

1. What has felt unique to us about our individual experiences as music therapy students in this time of a global pandemic?
2. What do we each perceive as being collective experiences we have had/are having during this pandemic?
3. What has been left unsaid about our experiences as students right now from the words written thus far that might be expressed through our individual creative practices? What does this creative response provide for each of us which words cannot fulfil?

Although the first shock of lockdown and the abrupt change to everyday life had lessened to some extent by the time we came to write, we all faced challenges as we translated our experiences into words. Many different emotions came to the surface: a sense of re-living the stress of the initial lockdown as we re-visited our feelings and experiences; feeling unable to capture the enormity of the experience; wondering whether those who studied during this time will be seen as equally competent as graduates from previous years; where to go from here for those of us who have graduated. Every response in this report is entirely unique; there are accounts of grief, loss, and lethargy. There are descriptions of new-found energy and opportunities. There are responses that focus on individual experiences and others on broader views of greater issues that followed in the pandemic's wake, such as mental health issues, social justice movements, and the changes in behaviour that helped citizens of the world cope with the unprecedented alterations to everyday life.

In light of these broader and complex issues that swept across the world, we acknowledge that we write from positions of privilege. Nethaniëlle, Karin, Cara and Liana have also included some theoretical underpinning from their own research and empirical understanding of the content discussed. Each of us also included a creative response to the COVID-19 pandemic, in the media of crafts and music.

We hope our stories provide a shared framework of the experiences of music therapy students in the aftermath of extraordinary global circumstances. Perhaps this framework may offer insight for music therapy educators and support systems of music therapy students on how similar occurrences may be perceived and experienced in the future and what parameters of support may be needed. We hope our narratives contribute to understandings of connection, relatedness, and collective being and that you may find yourself in one of our stories.

Nethaniëlle's response

When we started talking about how the five of us would approach this report, we came up with three questions. The first question being "what felt unique to us about our individual experiences as music therapy students in this time of a global pandemic?". This question initially seemed quite straight forward to answer, until I started thinking about it more deeply. How does one even begin to think about the concept of uniqueness in experience in the midst of a worldwide pandemic? How can I focus on my unique experience when this is such a collective disaster that has impacted others far worse than myself? That brings into question to what degree our experiences are actually unique or similar.

Music therapy is still a very unknown and ever evolving profession in South Africa. Our master's training course is the only one of its kind in Africa. Luckily due to the nature of our distance learning, we were able to continue our weekly online classes as we normally would; however, our face-to-face contact with each other during blocks (i.e. in-person intensive learning opportunities), which took place three times a year, had to be cancelled. It was during these blocks that we really had the opportunity to connect with each other on a very deep level through experiential learning. However, the biggest loss experienced by our group would be the cancellation of in-person therapy sessions with clients. Since March of 2020, most of us have not seen a single in-person client. The one thing that was most students' core reason for studying again – working with clients – was taken away. More so, I believe that in the midst of a pandemic governed by social distancing and isolation, being supported in the same physical space is what most people need. All we can do is settle for the second-best option, taking therapy to the realm of the online world. This has however emphasised the big gap in access that already existed in our country. Not only for clients, but for students across the board. Many students outside of our music therapy course have been unable to access online teaching. The university has tried its best to narrow this gap by providing students with laptops and data to create opportunities for students to attend online classes. This however is an unattainable goal when it comes to access to therapy for people in impoverished areas. If access to therapy was already so limited, how much more is it now because of the governance of the pandemic through social distancing and isolation?

Various reports have shone a light on the mental health "pandemic" that is accompanying the COVID-19 pandemic (Dubey et al., 2020; Pfefferbaum & North, 2020; Rajkumar, 2020). Many of these mental health repercussions have been due to higher levels of anxiety and fear, but what if you do not have access to information regarding the coronavirus? What if you have much greater fears than being infected with COVID-19? Holmes et al. (2020) explain that there are various socioeconomic effects of the strategies used to manage the spread of COVID-19. Unemployment, increased anxiety and increased feelings of loneliness are but a few of these effects. As outlined in an article by Steward (2020), the management of the COVID-19 pandemic is so reliant on risk and the unknown that it is almost impossible to anticipate every outcome of the precautions put in place by governments to manage the spread. In South Africa, the COVID-19 pandemic coincides with a massive increase in gender-based violence (Stiegler & Bouchard, 2020). This highlights how, even though there is some sense of a collective experience, the experience of the consequences of the pandemic are very context specific. This leads to the next question: "what do we each perceive as being collective experiences we have had/are having during this pandemic?".

Collective versus unique experiences, I believe, do not stand in opposition to each other but are intertwined in the small nuances of our experiences. The collective unconscious (Weinberg, 2016) is something we often refer to in therapy, but what has the impact of the collective unconscious been during this worldwide pandemic? How is it that, during one of the greatest devastations to hit the entire world since the world wars, protests have increased, there have been more publicised social justice movements across the world, and the massive gap between privileged and underprivileged has never been so magnified? Is there possibly a relationship between the vast ramifications of the pandemic and the social justice movements we bear witness of?

As I am writing my contribution for this report, I am struck by my privilege to discuss my experience as a music therapy student during COVID-19 while there are so many people who are faced with great difficulty across the world. How is it that once again the articles being published are written by, read by, and perceived by the privileged? I am struck by the timing of our writing this report during a period of great emphasis on social justice and equality. Where is the balance and integration of those with access and those without? There is a saying that I have heard a few times stating that it is better to cry in a Ferrari than on the street. Is this true? How did these kinds of statements come to exist? I am not trying to dismiss the discomforts and struggles experienced by those living in the world of privilege, as I am aware that I am extremely privileged. Here I am sitting in-front of my computer accessing my coursework online, being able to continue my academic journey and easily finding references on our online library. This is not the case for many other students within the South African context. I therefore believe the collective experience is not collective. A lot of pictures on Facebook and Instagram have tried to explain that in the midst of this storm that is upon us all, the 'boats' we are in differ vastly. This lockdown and pandemic have caused me to greatly reflect on what it means to really look at my privilege but to do so with soft eyes; recognising how I benefit from my privilege and owning up to how this impacts others, but not living in a constant state of guilt and shame. I want to keep reflecting on my life and my purpose. In a time where loss, pain and grief are experienced on such a big scale, I feel the need to slow down and notice. Notice the pain; notice the heartache and loss; notice the frustration, the anger and the injustice that is magnified at the moment. In this noticing

I think it is also important to also notice how in a time where the world has been turned upside down, we have stepped up to re-evaluate how we do things. To notice how the collective has answered the call to think outside the box and be creative.

> ***Nethaniëlle's creative response***
> I haven't spent much time actively making music. One day during lockdown after a particularly challenging case that I was holding I felt the urge to go sit in front of the piano and this improvisation is what emerged. I just remember feeling relieved allowing the music to hold the complexities that I was experiencing in my body.
>
> *[Nethaniëlle's recording is available online on the report's webpage]*

As I conclude this section, I am left with a sense of deep reflection on the diversity of the "collective" experience and how it is not that collective after all. It is truly difficult to integrate my experiences of the past 16 months as we are still in the midst of the South African COVID-19 storm, and I know the repercussions of this pandemic will sound for years to come. There is a quotation by Maya Angelou that reads, "I did then what I knew how to do. Now that I know better, I do better." That is all I can hope for myself and for those reading this, may we do the best we can, but always seek to learn and do better with the knowledge we have gained. May we enter each day with new eyes and insight as we strive to be better.

Karin's response

Being a music therapy student in South Africa comes with many questions from friends and family regarding what music therapy is. There is still much uncertainty under the general South African populace over what a music therapist does. With the advent of the pandemic and South Africa's lockdown in full effect, we have had to conduct music therapy sessions online. This has proven to be quite a feat, with new clients who have never experienced music therapy and who might also sit with the questions above but now can only receive feedback to their questions remotely. I have become very uncertain about my work during our lockdown period, often feeling anxious before online sessions with clients. On top of working hard at learning to become a therapist and showing up to sessions despite the heaviness of uncertainty in my own skill set, the online platform to music therapy has added anxieties over internet reception and containment for myself and my client.

The question of accessibility to music therapy services in South Africa during this pandemic has posed significant challenges to both music therapy students, registered music therapists and clients. We were acutely aware of the need for our services as our society's mental health and well-being needed urgent attention during this pandemic (Naidu, 2020). Some answered this "call to action" through creating a tele-therapy service called Frontline, in which clients are assigned therapists for sessions through an online platform. The trend of moving to online sessions in order to continue service delivery to clients during the time of the current pandemic seems fairly common internationally (Gaddy et al., 2020). Whilst this has increased clients' accessibility to music therapy services, it has changed the nature of music therapy sessions: for example, our clients do not have access to the

range of instruments we would have brought to sessions, which minimises the instrumental range of possibilities within musicking together or alone. As a music therapy student, I felt uncertain about my skill set, an uncertainty that was compounded by my now having to use an online platform with which I was unfamiliar. It seems inevitable that future courses in music therapy, then, would address methods of working online with clients in order to increase the student therapist's ability and confidence in this area. Telehealth services has been a blessing, especially in South Africa, helping to address the issue of accessibility to mental health services in the country. This has addressed the issue of accessibility significantly.

Online music therapy service delivery still comes with various complications. The unemployment level in South Africa has risen significantly since our lockdown, increasing the amount of individuals living in poverty and the burden on the mental health field. Many individuals therefore cannot afford phones, laptops, and/or data to use in order to attend online sessions. Because of many people living in one house in impoverished areas, privacy during sessions has also become a hurdle. Access to online mental health services which can promise a space of privacy and confidentiality to the client still remains a challenge.

Our music therapy course in South Africa is run through distance learning, with intensive practical and theoretical learning taking place during "block sessions" at the University of Pretoria. During these sessions, we had a chance to bond with one another as students and to gain valuable in-person training in a number of skills needed to become a music therapist. Since South Africa's lockdown, these block sessions have had to be cancelled. We thus went from expecting two more block sessions this year, to accepting that we will be finishing our degrees without any further block sessions. Our disappointment at the necessary cancellation of these block sessions were two-fold: our chances of becoming closer as a group in person and of receiving valuable in-person training were suddenly taken away.

In my opinion, there has been a "lockdown fever" taking place. Most people are not allowed to leave their homes during lockdown, except to buy essential groceries. I noticed a trend amongst my friends and family, and with myself, to engage less in self-care during the lockdown - wearing pyjamas all day, doing less exercise, changing mealtimes and going to bed at strange hours. Our routines were completely disrupted, and it was difficult to establish a personal routine without the help of a work/study routine that was set for us. Once my friends and family started leaving home for their workplaces, this trend decreased and personal care increased again. The trend seems linked to our sense of time passing during lockdown, something made evident by a change in our routine sleep patterns. As Cellini et al. (2020, p.1) state, "during home confinement, sleep timing markedly changed, with people going to bed and waking up later, and spending more time in bed, but, paradoxically, also reporting a lower sleep quality." An aspect that assisted in my sense of routine, structuring my day, and passing of time, was the online lectures that we continued receiving. I found myself hoping for more work and deadlines which would both serve to distract me from the ongoing pandemic and assist in creating a structured academic routine for each day.

As a frequent user of various social media platforms, I noticed and was influenced by various trends sparked by the pandemic and time of lockdown in various countries (Chun-Ying et al., 2020; Huddart et al., 2020; Nabity-Grover et al., 2020). Some trends seemed to have good intentions, but ultimately left many users (like me) feeling inadequate in not achieving its ideals. For example, in one

trend that would consistently pop up on my social media platforms, users were encouraged (even pressured) to use the time of lockdown constructively in terms of self-improvement through daily tasks such as exercising more, learning a new hobby or language, or even re-inventing oneself. My focus on social media has thus become one of balancing the reporting or posting of uplifting contents and the support of statements or posts indicating suffering or hardship. I believe it would be beneficial to music therapy students to receive training in how to support others informally through their own social media accounts as a part of their training.

I support the view that our collective mental health has suffered during this time of uncertainty and constant news updates about the virus (KwaZulu-Natal Department of Health, 2020). Within my circle of friends and family (including friends of friends), I know five people who committed suicide within the past month. Before this, I have only once met someone who later in their life died by suicide. This is an alarming rise which to me speaks of the helplessness and hopelessness many people feel because of COVID-19, lockdown restrictions, and everything related to this. In an article titled "Corona-associated suicide - Observations made in the autopsy room", Buschmann and Tsokos (2020) state that there has been an increase in suicides in the United States since the restrictions related to the pandemic. They suggested that special attention must be paid not only to those individuals susceptible to COVID-19, but those individuals susceptible to mental health struggles during such a time of crisis. Furthermore, they suggested the term "Corona-associated Suicide" be used in cases where an individual has committed suicide due to Corona lockdown effects (Buschmann & Tsokos, 2020). I can thus state that my life has been affected by five cases of Corona-associated Suicide, where before this pandemic I have only once been affected by a victim of suicide. I feel convinced that recent events have triggered the emotional vulnerabilities of many individuals to such an extent that a pandemic of mental illness might now be upon us. It seems important to me to advocate for accessibility to mental health services and to educate one another on how to support those amongst us who are struggling with their emotional well-being.

Karin's creative response

My creative response was in the form of a musical improvisation in which I accompany my singing on the piano. As I have lost loved ones during this pandemic, my improvisation focuses on the experience of Corona-related loss in its many forms. There is a sense of inertia, emptiness, and powerlessness in the largo music – all feelings that I have experienced in relation to the pandemic; yet there are also moments of breaking free and gaining momentum, symbolising my search for love and connection during a time where we were physically removed from one another, at accepting what humanity is now facing, and at envisioning my life forward with the potential "new normal" this pandemic brings. You might also hear a reference to "The 2nd Law: Isolated System" by Muse.

[Karin's recording is available online on the report's webpage]

Cara's response

I arrived in Cape Town on 28th January 2020 with one suitcase, a guitar, and a neatly written agenda of goals and objectives for the months ahead. I was temporarily moving to South Africa from the US to complete the final year of my master's degree at the University of Pretoria. A classmate of mine very graciously offered to host me in a small attic room at the very top of her Cape Town home. I was thrilled to take this next step in my education as a music therapist.

I had every step of this trip planned with fastidious precision. My student visa was due to expire on April 1st, giving me a narrow window of time to accomplish all the things I needed to do. My day planner and agenda consisted of densely written lists like a ship's logbook as I attempted to map out the six months that lay ahead.

Shortly after my arrival, coronavirus spun its web across the globe, and suddenly my meticulously planned itinerary disintegrated. Lockdown struck the city of Cape Town in March and working face-to-face with South African communities became a bygone idea. Border closures brought my research study to a grinding halt. The World Congress of Music Therapy was quickly cancelled as an in-person event. To say the carpet was ripped from under my feet does not quite articulate what this collapse of order, expectation, and certainty felt like. With the expiration of my visa looming, and the world shutting down door-by-door, I was confronted with a pivotal choice: should I stay, or should I go?

You may notice how each story you read in this report contains its own uniqueness and extraordinary circumstances, however each of our stories shares a common ground. My colleagues and I are aiming to make sense of our individual experiences within the greater context of this moment in time we all experienced. The circumstances of my being in South Africa, as a student from abroad with a soon-to-expire visa, makes my experience with the pandemic rather unique. However, I also felt this sense of participating in something greater and collective, and I knew I was not alone. From my tiny attic room, on the other side of the planet, far from home, I closed up the spiral notebook that contained my fastidiously written and color-coded agenda. April 1st was approaching – I watched it form like a wave on the horizon. Cape Town's surfing culture is quite similar to that of the Jersey Shore, where I grew up. You learn from a young age that to cooperate with the surf you cannot control or fight against the waves – you must lean into them, submerge yourself, and only then can you arrive on the other side. Not knowing how big of a swell this would be, or how far it would carry me, I chose to let go, take a deep breath, and dive in.

I believe everyone experienced a great exhale when the world shut down. Suddenly, all of our time-sensitive deadlines and extensive obligations disappeared, and we were all confronted with an unfamiliar but most welcome stillness. I imagine it was an exhale heard around the world on the precipice of the global lockdown. In recent years I have been reading more about how my generation, the Millennials, are considered the "burnout" generation (Petersen, 2019). In painting the greater context of the world at this very transformative point in time, I think understanding the burnout generation is extremely important. The context of what the world was doing before lockdown, and how many of us were going at an unsustainable, freight-train speed (myself included) helps me make sense of my individual experience. I am entirely guilty of participating in the burn-out culture. I have always over-extended myself work-wise, professionally, and socially, playing a part in the collective discourse

of how we all need to hustle ourselves to the brink of exhaustion and work ourselves to the bone in order to survive financially in today's world, find professional fulfilment, and adhere to the expectations of our families, peers, and society.

A reprieve came with lockdown – it was a global "snow-day" so to speak, where school was cancelled, and it was acceptable for everyone to stay at home in their pyjamas. I cannot be the only one who was grateful for it at the very beginning and seeing how the pausing and dismantling of the world's "fixed" and "strict" systems changed things forever.

The countereffect of this, of course is another kind of burnout: lockdown burnout (Shayak & Rand, 2020). The parameters of lockdown had complex psychological effects for everyone. Everyone experienced a disruption of routine (Sibley et al., 2020), changes in sleep (Leone et al., 2020), changes in basic day-to-day life, hygiene patterns, habits, and a feeling of connectedness with others. Not to mention, everyone's connection to the world, their work, and education became entirely computer based. Relentlessly staring at screens all day and interacting with people electronically, hearing voices through speakers, is not conducive to what we need as human beings, what our brains are designed to take on for long periods of time, and what our spirits need for peace, connection, and centredness (Sharma et al., 2020).

While in some ways I was able to keep lockdown burnout at bay, I also felt the heaviness on my psyche at the loss of personal contact and an oversaturated day-to-day technological life. I attended the World Congress of Music Therapy on my laptop, and while the fanfare, excitement, and pride of the first World Congress being hosted by an African institution was rightfully preserved, I still could not shake this overwhelming feeling of grief.

This monumental shift in my life offered new opportunities and directions. I enrolled in an acting course via Zoom, and began a new journey in film acting, something I had wanted to pursue for many years, where I probably would otherwise not have had the courage to do in any other circumstance. I grew closer to my housemates and participated in "family dinners," game nights and DIY projects around our house. I became less of a temporary tenant in the attic and more of an established member in the household (although I still cherish my endearing nickname of "the attic house elf"). I developed the healthy habit of doing yoga every day, mostly on our rooftop with Table Mountain in view.

In the end, my decision to stay in South Africa and sit in the stillness resulted in the greatest and most profound shifts and change in my life. I feel my career, health, and spirituality shifted and evolved because of the pandemic. As of September 2021, I write this not from my attic room, but from my own apartment that has a view of Cape Town harbour and the city's central business district. South Africa has phased out of lockdown, where now music therapy students are able to obtain in-person clinical hours in the community. I currently facilitate music therapy groups with my classmate at three different community sites, working with a diverse range of ages and ethnic backgrounds. South Africa's Department of Home Affairs has pardoned all expired visas and allowed for extra time for renewal applications to be made. I have an acting agent in Cape Town and continue to grow creatively and emotionally with each audition and self-tape. My housemates and I still have family dinners and they have become my central locus of love, holding, support and family. It has been an incredibly dynamic and incalculable journey here, but I am so happy with my decision to dive into the unknown with a held breath of hope and courage. Technically, my visa is still expired, but my life here has only just begun.

Cara's creative response

Before moving to Cape Town, I sang and wrote songs for a metal/goth rock band! The lockdown period not only allowed me more time to focus on writing and creating for our next album, but goth/metal aesthetic in music and artwork was always a means of escape for me. When my imagination needed a change of scenery, and I needed an alternative world to escape to, I dove into writing this genre of music. This "metal ballad" is an acoustic version of one of our soon-to-be released songs. It captures feelings of isolation and emptiness I am sure was felt collectively across the world.

[Cara's recording is available online on the report's webpage]

Holly's response

When a month-long nationwide lockdown was announced in New Zealand on 23rd March 2020, to start in two days' time, it only took me seconds to decide to hunker down at my childhood home with my parents. The sparsely populated and bush-covered Catlins area at the bottom of New Zealand's South Island where I grew up is a world away from the exposed and busy capital, where I rented a room and made polite small talk with my housemates. I whisked an email off to my parents confirming my plan, bought a ticket, and began to pack. Apart from new domestic travel regulations that required a change of flight, my decision to leave the city was an easy one and was easily carried out. I proceeded to spend the next two and a half months with my parents and although I could not continue the placements relevant to my research, I felt incredibly lucky to spend the time in a calm rural setting, relishing the sense of isolation and change from everyday life.

As a student still finding her feet in the music therapy world, the two and a half months that I spent outside of Wellington and removed from my placements served me well – it eased the pressure of placements while allowing me to reflect on my experiences so far and consolidate techniques and approaches that I felt worked best for me. I was able to continue with aspects of my placements through video calling, in the form of group music sessions with children and professional development meetings. Contact with my classmates and lecturers moved exclusively to video calls, but this was not a great change for me as I would sometimes utilise that option before the pandemic, when necessary. Thinking back to our first year of the course when our classes were held four days per week and when we would study together for various assignments, I imagine that the lack of face-to-face contact would have been much more disruptive for the first-year cohort who would still have been getting to know each other and coming to grips with the coursework. Our lecturers also worked fast to contact other support services in New Zealand who moved online, giving me and my classmates the chance to support children and families through musical interactions. However, there was and still is to a degree, a sense of guilt attached to those months when I was released from many responsibilities – the speed with which I left Wellington and the sense of release that I experienced during those months made me wonder and sent me back into a whirlwind of questioning my current path and my future options. I am sure that others around the world will have had a similar experience to mine during the early stages of the COVID-19 lockdown – quietly enjoying the novelty of the situation and the departure from their routine, at least for a time. However, I can now look back on that period as

providing me with necessary time and space for self-care, reflection, and reconnection with my motivation for the course.

Although our experience in New Zealand at the beginning of the pandemic was relatively unique, in that our geography allowed us to have the ability to eliminate COVID-19 from our population completely, this was a collective experience achieved by the efforts of the whole population.

Although some people in New Zealand were badly affected by the economic impact of the initial lockdown, on the whole we were able to return to life as normal from the end of May to the second week of August 2020. Since the second half of August 2020, the situation here has changed. There has been an outbreak of a different strain of COVID-19 in Auckland, the origin of which has still not been identified. This has meant reimplementing the lockdown levels - Auckland at level 3 and the rest of New Zealand at level 2, with care homes nationwide going into level 4 lockdown, independent of the government, to protect the most vulnerable to the virus.

There is no doubt that concerns about our own health, that of our friends and family, how we can support ourselves financially and how long we will be in this predicament are global concerns during this pandemic. In terms of the global student population, I am sure that both secondary and tertiary students are experiencing a lot of uncertainty around their futures as well. The delay in completing the necessary practical aspects of qualifications like music therapy and many others, may have ripple effects that cause more anxiety and stress for students who are soon to graduate.

Many courses and professions, including music therapy, require many practical hours to complete, and although some aspects of practicum work can be continued through video calling, it is very different from one-on-one interaction. In terms of therapeutic training, so much of relating to another person and building a therapeutic relationship is through observation of their body language, their facial expressions, etc., which may not always be easily seen through a camera and requires a reliable internet connection. Being physically present also allows music therapists to assist the people they work with, helping them to engage in therapy in different ways, such as holding and playing instruments, dancing to music, or simply actively listening. However, one collective benefit of this pandemic has been that we have been able to see what music therapy looks like without physical presence of the therapist. Although this also brings the definition of music therapy into question, we now know what is possible through screens alone – we are able to continue providing therapy through connection, through reflecting on music together, and through supporting families and children with music resourcing, for instance. Being forced to test these ideas by the COVID-19 lockdown is likely to have been beneficial to the profession in New Zealand (where music therapy is still relatively new compared to the United Kingdom and the United States), in terms of increased exposure of the therapy and by creating opportunities for remote work.

Lockdown gave me permission to immerse myself in creative projects (see Image 1). Having something to do with my hands changed how I viewed the lockdown months with my parents. Working on these projects stopped me becoming overwhelmed by worries about the future and served as a reminder that I am capable of finishing what I start as long as I give myself the space I need to do it - I will finish this course despite COVID-19!

I finished carving a bone pendant with a single twist/figure of eight shape (pikoura), and learned how to harvest, prepare and weave harakeke (flax) into small baskets and eventually a large bag. It is Māori custom to give your first of your creations away, and these were the first of both carving and

weaving that I had successfully finished. The bag went to my mum, and the pendant to a new cousin in Great Britain, born just before the UK lockdown.

Image 1: Holly's creative projects

Liana's response

Reflecting on my experience as a music therapy student at Queen Margaret University during the COVID-19 pandemic, I am struck by the timing of lockdown in relation to my studies. Dissertations and other remaining coursework were due by the end of April 2020 and graduation was planned for mid-July. However, as COVID-19 travelled to Scotland our course leader and lecturers had to adapt incredibly swiftly to the new circumstances. One of the most significant changes, therefore, was how our ending took place: after two years of full-time study together we would be saying goodbye online, rather than in person.

When lockdown took effect in Scotland it was mid-March. Placements were nearly finished and some of my peers were unable to complete their final sessions with clients. I was in the midst of finishing my dissertation in March and April and the emotional impact of the pandemic felt largely suppressed (Cramer, 2006). This defense strategy aided my concentration for writing, however, repeated tension headaches at the time reminded me that something was not being processed. My headaches became a source of anxiety in their own right, and coincided with an old lower back pain which worsened from increased sitting.

Upon reflection, it seems apparent that there was a connection between my physical symptoms and my psychological state. Physical pain can awaken psychic pain within "that needs to be suffered to be endured" (Byrne et al., 2019, p.7). The current grief I hold over the many losses experienced during

COVID-19, including finishing my studies online and qualifying at a time of such uncertainty, feels like the psychic pain which I have needed to *consciously* suffer in order to come to terms with my experience of this past year.

The onset of this grief (though I would not have recognised it as such at the time) began in late April when final goodbyes with lecturers and peers took place virtually. I was struck by the paradox of our physical separation when being "together" and felt dissatisfied with the course ending online. I missed being able to share final hugs with peers whom I had journeyed with for two years, particularly as some were returning to their home countries. There was an inevitable difference as well in the timing of our goodbyes: rather than a train journey home providing time for reflection and "metabolizing" (Bauer, 2020), my student experience was abruptly finished as soon as I clicked out of Zoom. Our lecturers had created closure as best they could, however, I found the online format made it far too easy to mindlessly begin a new activity (such as checking my email) without pausing from what came before. As Zinkin (1994, p.18) notes, "there is a great difference between bringing something to an end and just stopping," and this left me wondering: was I able to bring my student experience to an end, or did it just stop?

As I shifted from being a busy student to being newly qualified and unemployed, Scotland's lockdown dictated that most of my time was spent in the flat I shared with my partner in Edinburgh. I felt grateful and guilty over the unlimited time I had each day to spend as I wished but also longed for the social and creative activities I usually took part in in my Edinburgh community. I became increasingly homesick to a degree I had not experienced in years. The coinciding expiration of my US passport (I am a dual citizen) made my yearning for the comfort of the familiar – family, friends, and landscape of Vermont, even more evident. Having intermittently lived abroad from a young age, home was never found in one place, and yet, during this time my love for Vermont's flora and fauna (including its people) expanded and deepened. It was clear to me that my well-being depended upon eventually leaving the city and returning to the wilderness which I love so deeply. COVID-19 was reminding me of my roots.

While questions of identity and place were living within me, I was also struggling to make sense of my complete withdrawal from my usual music, movement and art practices. I noticed that the *urge* to create felt completely inaccessible and my first response was to feel incredibly guilty. Being a newly qualified music therapist I expected myself to use this time to expand my musicianship. The internal pressure left me further paralysed however, and I felt unable to even touch my cello. I was consumed by fear: what had happened to my desire to create?

Winnicott (2005) believed that play (in its broadest sense) was a prerequisite for access to creativity in the individual. During this time of personal transition and the global COVID-19 pandemic I was not in a state of play and perhaps that is why being creative felt so difficult for me. A recent study (Du et al., 2021) on the psychological impact of the COVID-19 pandemic on mood and ensuing creativity in Chinese university students provides further insight: an increase in low mood due to the COVID-19 pandemic was found to inhibit students' cognitive creativity (the ability to problem solve and think creatively) while increasing their emotional creativity (self-reflective and adaptive capacities).

Both Winnicott's (2005) understanding of creativity and Du et al.'s (2021) research findings have felt relevant to my experience, however I am unsure how emotionally creative I have been, as rumination may have replaced self-reflection. I do know, however, that I found immense comfort in the

reading of good literature and time spent in nature. Additionally, reading music therapist Martin Lawes (2001) moving account of his own journey towards health through musicking and psychotherapy has deeply inspired me as I continue to excavate my own complex relationship with creativity and music making.

In closing, I believe that the impact of COVID-19 on me as a newly qualified music therapist has been to feel trapped in liminality as the holding environment (Winnicott, 1984) of my trainee community, with its clear expectations and assignments has given way to a jobless, unsure future. I have left my student identity behind, but have not yet found my emerging professional identity either.

In February of 2021 I was able to return to my family home in Vermont to become a caregiver for my grandmother and the need to express myself through songwriting has re-emerged. Its arrival has felt delicate and related to my more hopeful state of mind since returning home. Of the two songs I have written, the most recent one (as of yet untitled) has felt like an expressive outpouring of my experience of the past year. It seems that the creative framework helped me explore my emotional experience in a very visceral way and has reminded me of how powerful the songwriting process can be as a tool for self-reflection (Baker & Wigram, 2005). For this reason (and though it feels incredibly vulnerable to do so) I have chosen to include this new song here as I believe there is no better way to convey my affective experience of the past year to the reader. There are many points of connection between what I have written here and what my lyrics reveal, and so, I hope that together the written and the sung will convey a richer picture of my life this year as a student, young professional, and situated person living within the time of the global COVID-19 pandemic.

Liana's creative response

Broken open, drawn to the raw/ Fingers dip in deep dark mud/ I pull them up, I take a look and see

How a tear speaks louder than any word/ How my singing's stopped but my voice is heard/ How strong the feelings of love and hate can be

So when women were birds[1] well where was I?/ Exquisite tenderness was by my side/ I'd like to love you down to my core, just tell me how

When days become dark, I just wanna run away from me/ Your love is too strong, I blame you for this intimacy/ You look, I want to be seen, and you look, I don't want to be seen/ Today, I'm afraid

Unemployed, overqualified/ I guess it's time to admit my pride/ And make amends with this old friend, and be

A woman in grief who's learning how to love/ How to sing and how to rise above/ Neverending doubt and needless suffering

It's time to join the birds, and watch the sun go down/ Instead of fearing dark, looking forward to dawn/ And tenderness will guide me on my way

[Liana's recording is available online on the report's webpage]

[1] *When Women Were Birds* (2012) is a book by Terry Tempest Williams.

REFLECTION

The individual contributions shared here provide a rich account of the differing and overlapping experiences each of us has had since the onset of the global COVID-19 pandemic. While our initial convergence was initiated by our lecturers, all five of us share further intersecting identities as well: being women of European ancestry, being citizens of colonised countries (spread across three continents) and being well-educated and middle class. These shared identities highlight the continued presence of our shared colonial ancestry, which hovers as a silent thread between each of our stories as we grapple with the inequity of the world and how this reflects upon music therapy as a profession, and on us, as practitioners.

We name these most obvious shared identities for two reasons: 1) to make visible what often remains invisible, i.e., the 'white' perspective as 'neutral' (Isajiw, 1993); and 2) to link these identities with themes which have explicitly or implicitly arisen in our individual contributions including, isolation, loss and grief, identity, geographical place, belonging and home, the role of artistic practice in our lives, and equity and access for our clients. Last but not least, we are each music therapy students or recent graduates and thus our thinking has been shaped by our musical and therapeutic training – though how similar each of our music therapy "world views" are, would require further inquiry.

While Liana's master's programme in Scotland was full time and in-person, Cara, Karin, and Nethaniëlle's master's programme in South Africa was part-time and low residency, and Holly's master's programme in New Zealand was a combination of both. Within the parameters of this report, the variation in voice, writing style and theoretical orientation is also noticeable, as is the level each of us chose to emphasise – from the sociological to the inter- and intrapersonal. These differences are interesting to consider, and may be a reflection of the influence of each of our training programmes on our thinking.

In this report each of us offer glimpses into our overall experience since the onset of the COVID-19 pandemic in spring 2020. For some of us, a deep sense of isolation and/or anxiety permeated our lockdown experience, where mounting self-pressure and worry went hand in hand with stilted creativity and difficulty maintaining self-care and structure in daily life. For others, lockdown became an opportunity for positive lifestyle changes including slowing down, thinking critically and deeply, devoting more time to creative pursuits, and deepening connections with those in one's immediate vicinity. None of these experiences were mutually exclusive however, and each of us experienced our own unique combination of positive and difficult outcomes. Importantly, we each wrote about moments, activities, or places of comfort that aided in combating the uncertainty of the COVID-19 pandemic. Many of us felt both grateful and guilty over our personal circumstances regardless of our overall experience of 2020 and 2021. Our geographical and cultural situatedness was also important, though for those of us studying abroad, this situatedness was ever evolving, as the practical and emotional difficulties of being a foreign student during the COVID-19 pandemic raised questions of place and belonging.

Lastly, the very real mental health crisis which has accompanied the COVID-19 pandemic was raised as a deep concern for many of us, particularly as it pertained to the growing disparity in service users' access to mental health services based on income and race. These concerns were also deeply personal, as Karin's contribution poignantly illustrated.

The artistic contributions that are included offer further insight into the ways art making was part of each of our lives this past year. For some, the change of state of COVID-19 allowed for more time to follow artistic interests, for others, however, creative output seemed to lessen. Artistic contributions were in multiple media and musical forms, including craft, song, and improvisation. Some of us explored a specific theme or culturally rooted practice while others kept an open-ended focus. The contributions seemed to serve multiple purposes for all of us, including as a means of self-expression, processing, reflection, and as a creative rendering of the overall experience of the year. For some, the artistic process seemed to be symbolic as well: of the relationship between the creator and the product or as an example of finishing something definitively despite the uncertainty of the times. As a collection, the artistic contributions felt strikingly tender and emotionally honest, and gave a strong sense of what we each might have been feeling or thinking about at the time of creation.

A significant theme overall was of individual isolation, loss, and for some, grief. All of us experienced the loss of in-person interaction with colleagues and lecturers. Those who were active clinicians were unable to continue working with clients in-person, and some were unable to continue working with specific clients at all, due to barriers in client access. Related to these losses, each of us also experienced an increased reliance on technology. Providing music therapy online raised many questions including concern over clients' ability to access online services, reflection about the client experience of online therapy, worry over the quality of the therapeutic experience and concern over what might be lost when moving to the virtual realm. Self-doubt over personal skill-sets and ability to adapt to online work was felt, as was mixed feelings about lectures and endings taking place online.

Lastly, it seems that all of us have been on our own journeys of exploring what it means to be an active citizen in the world and a music therapist of integrity. This has come to the fore during discussions in our online group meetings and is found within many of our written contributions. The amplification of global social justice movements such as Black Lives Matters were a specific influence for all of us. While some of us primarily focused on the racialised structural and systemic barriers facing service users, others focused on excavating the intrapsychic frameworks which uphold cultural constructs such as whiteness, race, and otherness (Dalal, 2015) where the process of integrating the shame which accompanies the recognition that one will forever be an "involuntary beneficiary" of ones' whiteness, even when it "contradicts one's fundamental values" (Suchet, 2007, p.874) remains deeply disturbing in its inabsolution.

When put together each level of focus appears valuable and necessary in our collective quest to be engaged citizens and reflexive music therapists. Questioning the structural systems in place and exploring our interior ideologies, particularly as they pertain to our colonial heritage are necessary things to grapple with, as these issues cannot be separated from our work as music therapists. As Suchet (2007, p.884) writes, "The paradox in creating this internal receptive state is that to unravel whiteness, to surrender, is to live more deeply in race." As emerging music therapists we wish to remain keenly aware of this, and to remember how it is interwoven with the power dynamics inherent in the therapeutic relationship. As Dalal (2015, p.192) states, "some people have the power to name, whilst others find themselves named."

CONCLUSION AND RECOMMENDATIONS

By sharing our individual experiences of this year as music therapy students and recent graduates, we have each offered a unique contribution to this report as a whole. The experiences shared were situated within our individual circumstances and therefore we cannot claim to have encapsulated the experience of other music therapy students during this time. However, this does not dismiss the profound feeling of togetherness and connectivity which many of us experienced during the global COVID-19 pandemic.

In conclusion, this collaboration has given rise to a number of thoughts and concerns which we wish to leave with the reader. As recent and soon to be graduates, we are concerned over our future as music therapists. We wonder what the impact of changes in our training programmes due to the COVID-19 pandemic will be regarding our ability to be "good enough" therapists. We wonder how the economic fallout will impact our chances of finding work in the future. For those of us (Liana and Holly), who have graduated since the writing of this report, difficulty in accessing reference material for this report due to student access to online resources being cut off is a further concern. With this in mind, we applaud open access journals like *Approaches* that provide access to all who cannot pay for costly journal subscriptions. Lastly, we ask programme directors and lecturers to be aware of the potential isolation and demoralisation students may experience as they transition from being trainees to graduates during this time of COVID-19 and into the future.

It has at times been a challenging process to write this report together due to constraints imposed by multiple time zones and our differing availability. For those who were students, deadlines and clinical work were in the balance, whereas for others, the writing of this report became a meaningful way to continue engaging as music therapists while being unemployed. Though Cara, Karin and Nethaniëlle knew one another before the writing of this report, the five of us together were relative strangers collaborating for the first time. While coordinating was not always easy, collaborating with students from around the world felt uniquely special and was an invaluable experience during this year of COVID-19. We hope this report will resonate with our fellow trainees and recently graduated colleagues, and if nothing else, has added to the questions already being raised in our global music therapy community.

REFERENCES

Baker, F., & Wigram, T. (Eds.). (2005). *Songwriting: Methods, techniques and clinical applications for music therapy clinicians, educators and students*. Jessica Kingsley Publishers.

Bauer, R. (2020). The great perfection of being a human being: The direct knowing of being and the metabolization of experience. *MenteClara Foundation Peer-reviewed Journal, 5*(142). https://doi.org/10.32351/rca.v5.142

Buschmann, C., & Tsokos, M. (2020). Corona-associated suicide – Observations made in the autopsy room. *Legal medicine (Tokyo, Japan), 46*, 101723. https://doi.org/10.1016/j.legalmed.2020.101723

Byrne, A., O'Connor, J., O'Raghallaigh, J. W., & MacHale, S. (2019). Something torn or burst or unbearable: A psychoanalytically-informed exploration of the experience of somatic symptoms. *Psychoanalytic Psychotherapy, 33*(1), 5-19. https://doi.org/10.1080/02668734.2019.1582085

Cambridge Dictionary. (2021, February 24). unique definition: 1. being the only existing one of its type or, more generally, unusual, or special in some way: 2…. Learn more. https://dictionary.cambridge.org/dictionary/english/unique

Cellini, N., Canale, N., Mioni, G., & Costa, S. (2020). Changes in sleep pattern, sense of time and digital media use during COVID-19 lockdown in Italy. *Journal of Sleep Research, 29*(4), e13074.

Chung-Ying, L., Broström, A., Mark, D. G., & Amir, H. P. (2020). Investigating mediated effects of fear of covid-19 and covid-19 misunderstanding in the association between problematic social media use, psychological distress, and insomnia. *Internet Interventions, 21*, 100345–100345. https://doi.org/10.1016/j.invent.2020.100345

Cramer, P. (2006). *Protecting the self: Defense mechanisms in action*. The Guilford Press.

Dalal, F. (2015). Prejudice as ideology: The creation of "us" and "them" groups in society (and psychoanalysis). *Psychotherapy and Politics International, 13*(3), 182-193. https://doi.org/10.1002/ppi.1359

Du, Y., Yang, Y., Wang, X., Xie, C., Liu, C., Hu, W., & Li, Y. (2021). A positive role of negative mood on creativity: The opportunity in the crisis of the COVID-19 epidemic. *Frontiers in Psychology, 11*, Article 600837. https://doi.org/10.3389/fpsyg.2020.600837

Gaddy, S., Gallardo, R., McCluskey, S., Moore, L., Peuser, A., Rotert, R., Stypulkoski, C., & LaGasse, A. B. (2020). COVID-19 and music therapists' employment, service delivery, perceived stress, and hope: A descriptive study. *Music Therapy Perspectives, 38(*2), 157-166. https://doi.org/10.1093/mtp/miaa018

Ho Holmes, E. A., O'Connor, R. C., Perry, V. H., Tracey, I., Wessely, S., Arseneault, L., Ballard, C., Christensen, H., Silver, R.C., Everall, I., Ford, T., John, A., Kabir, T., King, K., Madan, I., Michie, S., Przybylski, A.K., Shafran, R., Sweeney, A., …Bullmore, E. (2020). Multidisciplinary research priorities for the covid-19 pandemic: A call for action for mental health science. *The Lancet Psychiatry, 7*(6), 547–560. https://doi.org/10.1016/S2215-0366(20)30168-1

Huddart, D., Hirniak, J., Sethi, R., Hayer, G., Dibblin, C., Rao, B. M., Zaman, M. E., Jenkins, C., Hueso, B., Sethi, S. (2020). #Medstudentcovid: How social media is supporting students during COVID-19. *Medical Education, 54*(10), 951–952. https://doi.org/10.1111/medu.14215

Isajiw, W. W. (1993). Definition and Dimensions of Ethnicity. In "*A theoretical framework. Challenges of measuring an ethnic world: Science, politics and reality*" Proceedings of the Joint Canada-United States Conference on the Measurement of Ethnicity April (vol. 13, no. 1992, pp. 407-427).

Leone, M. J., Sigman, M., & Golombek, D. A. (2020). Effects of lockdown on human sleep and chronotype during the COVID-19 pandemic. *Current Biology, 30*(16), R930-R931.

Kwazulu-Natal Department of Health. (2020, August 25). COVID-19 Mental Health Toolkit. http://www.kznhealth.gov.za/mental/covid19.htm

Lawes, M. (2001). Aesthetic experience and the healing process: The story of a therapist's rediscovery of music. *British Journal of Music Therapy, 15*(1), 22-25. https://doi.org/10.1177/135945750101500106

Nabity-Grover, T., Cheung, C. M. K., & Thatcher, J. B. (2020). Inside out and outside in: How the covid-19 pandemic affects self-disclosure on social media. *International Journal of Information Management, 55*. https://doi.org/10.1016/j.ijinfomgt.2020.102188

Naidu, T. (2020). The covid-19 pandemic in South Africa. *Psychological Trauma: Theory, Research, Practice, and Policy, 12*(5), 559–561. https://doi.org/10.1037/TRA0000812

Pavlicevic, M., & Ansdell, G. (Eds.). (2004). *Community music therapy*. Jessica Kingsley Publishers.

Pfefferbaum, B., & North, C. S. (2020). Mental health and the covid-19 pandemic. *The New England Journal of Medicine*, *383*(6), 510–512. https://doi.org/10.1056/NEJMp2008017

Petersen, A. H. (2019). How millennials became the burnout generation. *AMASS*, *23*(4), 16-21.

Rajkumar, R. P. (2020). Covid-19 and mental health: A review of the existing literature. *Asian Journal of Psychiatry*, *52*. https://doi.org/10.1016/j.ajp.2020.102066

Sibley, C. G., Greaves, L. M., Satherley, N., Wilson, M. S., Overall, N. C., Lee, C. H. J., Milojev, P., Bulbulia, J., Osborne, D., Milfont, T. L., Houkamau, C. A., Duck, I. M., Vickers-Jones, R., & Barlow, F. K. (2020). Effects of the covid-19 pandemic and nationwide lockdown on trust, attitudes toward government, and well-being. *The American Psychologist*, *75*(5), 618–630. https://doi.org/10.1037/amp0000662

Sharma, V., Reina, O. M., & Sharma, N. (2020). Risk and protective factors for adolescent and young adult mental health within the context of covid-19: A perspective from Nepal. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine*, *67*(1), 135–137. https://doi.org/10.1016/j.jadohealth.2020.04.006

Shayak, B., & Rand, R. H. (2020). *Self-burnout-a new path to the end of COVID-19.* medRxiv.

Stewart, D. W. (2020). Uncertainty and risk are multidimensional: Lessons from the covid-19 pandemic. *Journal of Public Policy & Marketing, (20200528)*. https://doi.org/10.1177/0743915620930007
Stiegler, N., & Bouchard, J.-P. (2020). South Africa: Challenges and successes of the covid-19 lockdown. *Annales Médico-Psychologiques*, *178*(7), 695–698. https://doi.org/10.1016/j.amp.2020.05.006
Suchet, M. (2007). Unraveling whiteness. *Psychoanalytic Dialogues, 17*(6), 867-886. https://doi.org/10.1080/10481880701703730
Vinkers, C. H., van Amelsvoort, T., Bisson, J. I., Branchi, I., Cryan, J. F., Domschke, K., Howes, O. D., Manchia, M., Pinto, L., de Quervain, D., Schmidt, M. V., & van der Wee, N. J. A. (2020). Stress resilience during the coronavirus pandemic. *European Neuropsychopharmacology, 35*, 12–16. https://doi.org/10.1016/j.euroneuro.2020.05.003
Williams, T. T. (2012). *When women were birds: Fifty-four variations on voice*. Sarah Crichton Books.
Winnicott, D. W. (1984). *The maturational processes and the facilitating environment: Studies in the theory of emotional development*. Hogarth Press.
Winnicott, D. W. (2005). *Playing and reality*. Routledge.
Weinberg, H. (Ed.). (2016). *The social unconscious in persons, groups, and societies* (vol. 2). Karnac Books.
Zinkin, L. (1994). All's well that ends well. Or is it? *Group Analysis, 27*(1), 15-24. https://doi.org/10.1177/0533316494271002

Ελληνική περίληψη | Greek abstract

Παράθυρα εμπειρίας φοιτητριών μουσικοθεραπείας κατά τη διάρκεια του COVID-19

Liana Nuse | Karin Meyer | Nethaniëlle Mattison | Cara Smith | Holly McPhee

ΠΕΡΙΛΗΨΗ

Η πανδημία του COVID-19 έχει δυσμενείς επιπτώσεις σε πολλά άτομα. Αυτή η αναφορά επιδιώκει να διερευνήσει τον αντίκτυπο της πανδημίας στις ζωές πέντε φοιτητριών μουσικοθεραπείας. Τρεις φοιτήτριες από τη Νότια Αφρική, μία από την Σκωτία και μία από τη Νέα Ζηλανδία συναντήθηκαν για να γράψουν για τις εμπειρίες τους από τις σπουδές μουσικοθεραπείας κατά τη διάρκεια αυτής της παγκόσμιας επιδημίας. Κάθε φοιτήτρια μοιράστηκε τις απαντήσεις της σε τρία γενικά ερωτήματα, γράφοντας εκθέσεις, αλλά και με μη-λεκτικές δημιουργικές αποκρίσεις. Το άρθρο καταλήγει με έναν αναστοχασμό που συνδέει όλες τις επιμέρους συνεισφορές και συμπεριλαμβάνει μία σύνοψη των προβληματισμών που μοιράζονται ως φοιτήτριες μουσικοθεραπείας οι οποίες εισέρχονται στο επάγγελμα εν μέσω της πανδημίας του COVID-19.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

φοιτητική οπτική, φοιτητική εμπειρία, COVID-19, ψυχική υγεία, κοινωνική δικαιοσύνη, μουσικοθεραπεία

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REPORT

Special Feature | Reports on online music therapy

The Online Conference for Music Therapy (OCMT): Demonstrating best practices for virtual conferences, education and training

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ABSTRACT

This report highlights the Online Conference for Music Therapy (OCMT) and assesses the impact of the global pandemic COVID-19 on the education and training of music therapy students, as well as music therapy and music and medicine conferences. Virtual conferences and the future of conferences in general are overviewed, while best practices for virtual conferences are shared and connected to the OCMT exemplar. With considerable uncertainty regarding the long-term impact of the pandemic on face-to-face conferences and instruction, it does seem timely for a review or study of the feasibility of teaching music therapy courses online versus in class. With each online conference new knowledge is gained and best practices will continue to evolve. Given COVID-19, it is timely that the profession addresses the benefits and challenges of remote learning and telehealth practices for music therapy training. The music therapy community is fortunate to have the experience and practices of the OCMT to inform their virtual events during this pandemic.

KEYWORDS

education and training,
virtual conferences,
music therapy,
pandemic,
best practices,
OCMT

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This brief report highlights the Online Conference for Music Therapy (OCMT) and offers discussion on the impact of COVID-19 on conferences, education and training in the present reality and future. Best practices for virtual conferences are shared and connected to the OCMT exemplar.

SETTING THE STAGE: ONLINE CONFERENCE FOR MUSIC THERAPY (OCMT) REFLECTIONS

Each winter since 2011, I have looked forward to attending and presenting at the Online Conference for Music Therapy (OCMT). It is a virtual conference where music therapists and music and

healthcare practitioners from the eight global regions of the world are invited to present, learn and interact. While the conference is a live 24-hour event, each presentation is recorded and subsequently available to conference attendees for one month post-conference as part of their registration fee. This allows participants to attend live presentations that are congruent with their time zone, and watch additional presentations at their leisure. Some presentations are also archived with the permission of the presenter and kept on the OCMT website for individuals to purchase anytime during the year for a small fee. Further, attendees can register to earn Continuing Education Credits CMTE Credits, which are applicable for music therapists holding the Music Therapist Board Certified Credential (CBMT). For other attendees, Continuing Education credits are determined and issued on an individual basis. Organisers offer two options for the amount of credits to be earned based on the number of presentations an individual chooses to attend and/or "watch a recording of."

Each OCMT has featured two keynote speakers as well as an additional 14-16 presentations lasting 45-60 minutes with an opportunity for questions. The conference is held the first weekend of February each year, and an open call for presenters is put out in the spring the year prior to the conference. Presentation submissions are sent out for anonymous peer review and submissions must include an abstract, description of the presentation, learning objectives and a list of the relevant Certification Board for Music Therapists Domains that will be covered in the talk. Presenters are notified of the status of their submission in the early fall, giving them ample time to work on their presentations and become comfortable with the technological aspects if they are new to the online presentation platform.

During the live presentations, the OCMT board and volunteers support presenters as well as attendees and encourage interaction via the chat feature in the online platform, or through quick polls during the presentations. Further, the OCMT does a lot of social media leading up to the conference, during and after the event. Presenters have their own OCMT Facebook group to dialogue, and the OCMT team creates an encouraging and positive format to interact.

Online Conference for Music Therapy is a not-for-profit organisation that is overseen by the OCMT Board of Directors and the conference organising committee volunteers who prepare the annual conference event as well as additional symposia where CMTE Credits can be earned. The mission of the OCMT is to provide professional music therapy learning opportunities that are affordable and applicable to music therapy students, professionals and music and health-oriented individuals. I concur the fees for the online event are reasonable and accessible. Further, OCMT offers scholarships and a simple application process. They are truly striving to be inclusive and to reach as many individuals as possible with these learning opportunities.

My OCMT experiences

For the past nine years (since the conference began) I have attended and presented a paper at the conference. Each year as a presenter, I was supported by the OCMT team with respect to the technological aspects in preparing my presentation. The OCMT team offers online training for presenters well in advance of the conference, and they provide valuable feedback in assisting presenters to finalise their presentations. As a long-standing OCMT presenter, I have felt exceptionally well supported and prepared to present with the OCMT officers; and that the process

has been simple. I have promoted the event each year to the students I teach as well as my music therapy colleagues, and I have only heard positive comments regarding their participation.

I am honoured to be selected as one of the two keynote speakers for the 10th Anniversary of the OCMT in February 2021. If you have not yet attended an OCMT conference, I encourage you to do so, and also to consider presenting your work. This is a valuable learning opportunity music therapists and music and medicine practitioners have each year to become knowledgeable about music therapy and music and health practices around the world. A number of presenters often include the voices of the service users via various methods such as case examples, video and/or research qualitative comments. For more information about the OCMT, please visit https://onlineconferenceformusictherapy.com/

THE IMMEDIATE IMPACT OF THE GLOBAL PANDEMIC ON EDUCATION

As I am writing this report, the world is experiencing a global pandemic (COVID-19), and I am now framing my online OCMT conference experiences in the broader professional and interdisciplinary context. In less than one week in March 2020, many of my music therapy educator colleagues around the globe had to move their classroom delivery of music therapy courses to online platforms in order to complete the winter 2020 academic term. While moving online was necessary, student access to the internet and online platforms is something to be considered moving forward. Not all students have access to high-speed internet or even a computer that is dedicated for their own use as opposed to the use of several family members meaning there could be challenges in students attending synchronous lectures and accessing their online work and assignments. Other students may not feel comfortable turning their web cameras on to invite others into their home spaces. Further, the needs of the learner have to be considered and educators need to ensure that learning includes developing and enforcing accessibility standards. What has appeared to present one of the largest challenges is the practical aspect of music therapy training. With many placement and internship sites not allowing students to provide therapy during the quarantine, how do students continue learning, and stay motivated? Many training programmes created continuing education learning opportunities for their students to keep them engaged. For example, viewing clinical videos, or their supervisors providing online therapy and commenting, among other self-study activities. If the pandemic continues for several months or even a year with social distancing restrictions, there will be an issue in securing a sufficient number of placement sites and supervisors when the social distancing rules are eased and both new and current students. Consultation is occurring and dialogue will continue with certification boards in terms of how many of the required internship or placement hours can include other activities. Will there be consideration for a reduction in the number of direct client contact hours? And if so, does this put pre-professionals at a disadvantage compared to other cohorts? There are a lot of questions for educators, and several groups have assembled themselves over social media and begun the process of sharing resources and collaborating, for example the Philadelphia Area Schools Coalition of Clinical Coordinators in the USA.

THE IMMEDIATE IMPACT OF THE GLOBAL PANDEMIC ON CONFERENCES

Planned in-person music therapy and music and medicine conferences moved to online platforms. For several of these, I was involved in helping transition or support the reworking of the events; and it seemed the learning curve was steep and rapid. In some ways, moving conferences online enabled many individuals to attend conferences they would not have been able to, given financial and other limitations such as time away from work. Board members of OCMT reached out to help music therapy colleagues globally in re-envisioning their conferences for online platforms and to share their learning and knowledge; truly demonstrating their commitment to their not-for-profit organisation.

When looking at disciplines, some areas of study and focus are more readily deliverable over the internet. Music and music therapy provide challenges in online delivery. For example, with respect to sound delays when trying to create music together, or with the energy that is felt when one is performing and sharing music in the same physical space. Ethical challenges also surface as some online platforms have become hacked or the therapist or student therapist does not have a space in their home that is free from disruption from other family members potentially entering. How can a presenter feel secure to share a clinical video online? Do they worry that someone is recording that clinical video and will post it online? While it is possible for individuals to record a video during a live conference, it is easier to control.

VIRTUAL CONFERENCES AND THE FUTURE

Virtual conferences have become the 'new normal' and it begs the question about what will happen moving forward post-COVID-19 with respect to conference delivery modes. Guta (2020) confirms what many of us realise about the benefits of virtual conferences: no travel costs, lower registration fees, reduced environmental footprint and even investing more into speakers. Further, with the economic impact faced by many individuals, it may make it impossible to be able to travel to in-person conferences in the next few years. So, will conference organisers move completely online, alternate one year in person with one year online, or will hybrid conferences be the new norm? PM Live (2020) notes:

> Overall it is in everybody's interest - venues, cities, organisers, exhibitors, companies, airlines and delegates to get the exhibitions and events industry back to the pre Covid-19 levels of activity. After an extended period of isolation, there will certainly be an appetite for it. (para 18)

While I agree that there will be an increase in the desire to socialise and meet colleagues in person, PM Live's motivation for this statement comes from the framework of supporting the economy and takes into account the considerable financial hit that was taken in the hospitality industry. Mara (2020) asserts

> While I don't predict that in-person events will be replaced entirely after COVID-19, I do believe event organizers will figure out ways the digital aspects can complement in-person events. I predict a steep rise in hybrid events where parts of the event take place in person, and others are delivered digitally. (para 9)

Already nine years ago, Pullan (2011) noted that there was a dramatic increase in virtual meetings. Interestingly, Pullan stated these as reasons for the increase: "Volcanic ash clouds over Europe in Spring 2010; The fear of epidemics, such as swine flu; and the need to cut travel to reduce costs in an uncertain economic climate, with ever-higher petrol prices" (para 6).This dramatic increase in virtual meetings was not witnessed or present in music therapy conference platform changes. Planned music therapy conferences went ahead as scheduled in person. I myself was stranded in an airport for two days in Europe due to the volcanic ash. I had just presented at an international conference and was slated to return home to repack for a national conference. Due to the delay, I went straight from the international event to the home country congress.

VIRTUAL CONFERENCE BEST PRACTICES

So, what are important considerations in hosting virtual conferences? As I read the literature on best practices for virtual conferences, it is apparent that the OCMT have been demonstrating these since their inception and I have written about them above. Important considerations for hosting international online conferences include: the amount of screen time participants are logged on, synchronicity vs asynchronicity, time zones, live question-and-answer periods, and virtual networking and socialising. A balance of synchronous versus asynchronous presentations is essential, and many conferences offer this, with all presentations remaining on a conference website for a period post-conference, enabling attendees to view at their leisure. Adding this component also helps accommodate individuals in varying time zones and those with learning disabilities. Flaherty (2020) acknowledges that synchronous instruction does not often provide provisions for those individuals with special learning needs. It is also important to consider the voices of the service users and their conference participation opportunities as well as ensuring access for individuals with disabilities.

Keeping participants engaged is also vital to ensuring satisfaction, and providing a monitored live question-and-answer period and chat feature are essential tools. A great feature I used in my OCMT presentations was audience polls. This gives the audience a chance to share their voice/opinion, and also for the speakers to learn a bit about their attendees in order to further customise their talk. A concept I had not considered before the virtual conferences I attended this spring was a virtual networking time. As we all know, networking is often a key selling feature for in-person events, and it does deserve a place in the virtual world. How to make this happen virtually is slightly more challenging as people are not walking around a conference venue nor do they have the ability to approach a speaker they listened to with some further questions. Some ideas that come to mind are to have breakout groups where individuals can sign up in advance to network with a group about a designated topic. And, of course, entertainment which is something we as music therapists and musicians have an advantage of in terms of including in our events. For example, being able to feature the musician participants, and also to create virtual musical compositions, such as a virtual choir of selected participants.

FINAL THOUGHTS

Certainly, there is a lot to think about and a lot of uncertainty in how the globe will move forward in terms of in-person versus virtual events, teaching, therapy and much more. With respect to clinical training, it does seem timely for a review or study of the feasibility of teaching music therapy courses online versus in class, and a number of questions come to mind for discussion and research. Is there an implication / need for a profession-wide review of the amount or types of courses in music therapy education and training that can be taught remotely? Is it timely, given COVID-19, that the profession addresses this now as more professionals learn about the challenges and benefits of remote training? What cultural considerations need to be taken into account when moving courses and/or programmes online? With respect to ensuring pre-professionals are prepared for working with their clients given curriculum changes and clinical placement opportunities whose responsibility is to monitor that process? (i.e. the professional association or certification bodies or individual intuitions offering training).

With each online conference, new knowledge is gained and best practices will continue to evolve. The music therapy community is fortunate to have the experience and practices of the OCMT to inform their virtual events during this pandemic. While I greatly desire to see my colleagues soon at an in-person conference, it has been rewarding to connect with many individuals I would not have seen at these events but who have been able to participate virtually.

REFERENCES

Flaherty, C. (2020, April 29). *Zoom boom.* Inside Higher Ed. https://www.insidehighered.com/news/2020/04/29/synchronous-instruction-hot-right-now-it-sustainable

Guta, M. (2020, May 6). *Do virtual conferences have a future post-pandemic?* Small Business News. https://smallbiztrends.com/2020/05/virtual-conference-trends.html

Marr, B. (2020, April 14). *What does the future look like post-Coronavirus - 9 future predictions?* Future Trends: Tech and Business. https://www.linkedin.com/pulse/what-does-future-look-like-post-coronavirus-9-predictions-marr/

PM Live (2020, April 22). *How will the events and exhibitions industry change post-Coronavirus?* http://www.pmlive.com/pmhub/exhibitors/Apex_Conferences,_Events_and_Exhibition_Stands/press_releases/how_will_the_events_and_exhibitions_industry_change_post-corona_virus

Pullan, P. (2011). *The seven secrets of successful virtual meetings* [Paper presentation]. PMI Global Congress 2011—EMEA, Dublin, Leinster, Ireland. Newtown Square, PA: Project Management Institute. https://www.pmi.org/learning/library/successful-virtual-meetings-skills-improvement-6267

Ελληνική περίληψη | Greek abstract

Το Διαδικτυακό Συνέδριο Μουσικοθεραπείας (OCMT): Παραθέτοντας καλές πρακτικές για εξ αποστάσεως συνέδρια, εκπαίδευση και κατάρτιση

Amy Clements-Cortés

ΠΕΡΙΛΗΨΗ

Η παρούσα αναφορά επικεντρώνεται στο Διαδικτυακό Συνέδριο Μουσικοθεραπείας [Online Conference for Music Therapy, OCMT] και κάνει μια εκτίμηση του αντίκτυπου της πανδημίας COVID-19 στην εκπαίδευση και κατάρτιση φοιτητών μουσικοθεραπείας, καθώς και στη διεξαγωγή

συνεδρίων στα πεδία της μουσικοθεραπείας και της μουσικής και ιατρικής. Γίνεται μία συνοπτική αναφορά στα εξ αποστάσεως συνέδρια και τα συνέδρια του μέλλοντος γενικότερα, ενώ επισημαίνονται οι καλές πρακτικές των εξ αποστάσεως συνεδρίων σύμφωνα με το υπόδειγμα του OCMT. Με έντονη αβεβαιότητα ως προς τον μακροπρόθεσμο αντίκτυπο της πανδημίας στη διεξαγωγή των δια ζώσης διασκέψεων και διδασκαλιών, η επισκόπηση ή μελέτη της σκοπιμότητας των εξ αποστάσεως μαθημάτων μουσικοθεραπείας έναντι των δια ζώσης μαθημάτων είναι επίκαιρη. Σε κάθε διαδικτυακό συνέδριο αποκτάται νέα γνώση και οι καλές πρακτικές εξακολουθούν να αναπτύσσονται. Δεδομένου του COVID-19, είναι η κατάλληλη στιγμή για το επάγγελμα να εντοπίσει τα οφέλη και τις προκλήσεις της εξ αποστάσεως μάθησης και των πρακτικών τηλε-υγείας στην εκπαίδευση της μουσικοθεραπείας. Η κοινότητα της μουσικοθεραπείας έχει το προνόμιο να έχει την εμπειρία και τις πρακτικές του OCMT για να ενημερώσει τις εξ αποστάσεως δράσεις της κατά τη διάρκεια της πανδημίας.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

εκπαίδευση και κατάρτιση, εξ αποστάσεως συνέδρια, μουσικοθεραπεία, πανδημία, καλές πρακτικές, OCMT

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REPORT

Special Feature | Reports on online music therapy

Creating a COVID-19 Guided Imagery and Music (GIM) self-help resource for those with mild to moderate symptoms of the disease

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Integrative GIM Training Programme, UK

ABSTRACT

This report discusses the creation of a COVID-19 Guided Imagery and Music (GIM) self-help resource available on YouTube in nine different languages. GIM, which is a specialist area of practice in music therapy, is best understood as a spectrum of methods. The COVID self-help resource is an example of 'directed music imaging', which is an outcome-specific GIM method where a talk-over or imagery script is spoken aloud whilst the music is playing. The resource is intended both to support the body's own healing process in patients with mild to moderate disease and to provide psychological and emotional support. The suitability of the music used, Pärt's *Spiegel im Spiegel*, is discussed, as is the talk-over and its relationship with the music. Special concerns that needed to be addressed in creating a generic online GIM resource for COVID patients are also discussed.

KEYWORDS

Guided Imagery and Music (GIM),
COVID-19,
self-help resource,
directed music imaging,
talk-over,
Pärt's *Spiegel im Spiegel*,
music breathing

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INTRODUCTION, BACKGROUND AND THE PROCESS OF CREATING THE RESOURCE

In contemporary practice, Guided Imagery and Music (GIM) is best understood to comprise a spectrum of different methods applied in both individual and group therapy (Grocke & Moe, 2015). These methods generally involve the patient listening to pre-recorded music whilst imaging in a non-ordinary or altered state of conscious, though some of the simpler Music and Imagery (MI) methods employed involve the patient in drawing whilst listening to music in an ordinary state of consciousness. Research evidence suggests that GIM and MI may benefit patients with a range of mental health issues and medical conditions (Bonde, 2005; Grocke, 2019; Hertrampf, 2017; McKinney, 2019; Sanfi & Christensen, 2017; Torres Serna, 2015; Warja, 2018; Young, 2019). GIM is normally provided in person,

which has not always been possible during the COVID-19 pandemic. This has resulted in GIM therapists worldwide turning to online platforms such as Zoom.us to enable work to continue (GIM resources, 2020a, 2020b; Sanfi, 2019).

Beyond GIM there are numerous guided imagery self-help resources available online including many on YouTube. Most are created for general relaxation though some are intended to support medical treatment or healing from illness (Inner Health Studio, 2008-2018; Unlock Your Life, 2015). These resources typically feature New Age style music, nature sounds or similar provided as a quiet and unobtrusive background to the spoken guided imagery script. This contrasts with the situation in GIM where the classical and other music used tends to be more complex and has a central role to play in the patient's therapeutic experience. Indeed, the patient is encouraged to be aware of the music and to be open to its effects, bodily and emotionally. The music helps generate and structure the imagery experienced, and functions effectively as intersubjective participant in the client's therapeutic process (Lawes, 2016). Thus, the music is understood to be the co-therapist, even at times the principal therapist, in GIM (Bruscia, 2002).

In the Bonny Method of GIM, the original and best known GIM method, the client images freely and spontaneously whilst listening to the music, with the therapist providing non-directive verbal support. Some of the other GIM methods that have been developed involve the use of a talk-over or imagery script. The talk-over, which is spoken by the therapist whilst the music is playing, is intended to facilitate an imagery experience that is contained in a more focused and limiting way than in Bonny Method work, where the process is freely evolving. The GIM COVID-19 self-help resource, which is the subject of this report, is such a talk-over experience. It is an example of 'directed music imaging' (Bruscia, 2015, p. 17). Bruscia lists this as one of several GIM practices that are derived from, but also need to be differentiated from, the Bonny Method of GIM.[1] He describes how:

> the purpose of directed music imaging is to take the traveler [patient] step-by-step through an imagery experience that activates, reproduces, or rehearses a desired process or outcome, such as pain management, enhancement of immune responses, stress or anxiety reduction, healing of trauma, and healing of disease processes. Here, the image re-enacts a sequence of physical or psychological events that are deemed to be therapeutic for the traveler (Bruscia, 2015, p. 17)

There is little reference to the use of talk-overs in the GIM literature. However, Helen Bonny, the original developer of GIM, includes examples of what can be used as talk-overs in an early publication. I recently recorded a version of one of these on YouTube, "The Peace Composer" (Bonny & Savary, 1990, pp. 62-63), as one of a series of self-care resource for GIM therapists during the COVID epidemic (Self-care resources for GIM therapists, 2020).

In recent years, a few other GIM therapists have begun recording self-care resources for specific patient populations. Sanfi, for example, has been recording talk-overs intended to promote wellbeing in children with cancer undergoing chemotherapy (Sanfi, 2012; Pedersen & Sanfi, 2018). Messell and Pedersen (2019) have been recording similar resources as part of a project designed to reduce stress and support wellbeing in hospital staff.

[1] Bruscia (2015) lists 'contained spontaneous imaging', 'directed music imaging', 're-imaging' and 'interactive music imaging' as GIM practices that have been derived from the Bonny Method of GIM.

I recently embarked on a project to develop a GIM self-help resource, intended to be available on YouTube for members of the public suffering from mild to moderate COVID-19. Nothing of this type had been undertaken previously in GIM to my knowledge. The project began with informally researching the disease and consulting with medically trained practitioners to develop an imagery script intended to support the body's own healing process. I produced a test version of the resource and shared it with a number of experienced GIM researchers and other medical and psychotherapeutic practitioners in Europe and the USA.

One of the challenges I faced was finding suitable music and recordings that would not infringe copyright when I published the resource on YouTube. This severely limited my choices, with many of the GIM and MI pieces I considered using not available. Whilst I felt that the test version employing new age music worked reasonably well, I eventually discovered something that I felt had greater therapeutic and healing potential for my purpose - a concert performance on YouTube of Arvo Pärt's *Spiegel im Spiegel* (1978) in the version for cello and piano (Leonhard Roczek, 2014). Although I could have used the recording without copyright infringement, I sought permission anyway. This was granted by the cellist who owned the copyright (L. Roczek, personal communication, April 20, 2020).

I created a revised version of the talk-over, drawing on the feedback I had received from the GIM researchers and others whom I had sent the test version. I then used video editing software to combine a recording of the talk-over with Pärt's music, incorporating nature sounds to accompany an introduction to the talk-over, and a simple looped video image that would play throughout. The result uploaded to YouTube (COVID-19 Guided Imagery and Music Self-Help, 2020a).

BREATHING

Very often the relaxation procedures employed in GIM are breath-based, typically beginning with the client being encouraged to take a series of deep breaths. Through my research and discussion with medically trained colleagues, I soon realised that a breath-based relaxation procedure, and any attempt to guide the patient to take deep breaths, was contra-indicated in a generic resource of the type I was creating for COVID patients, some of whom may be experiencing breathlessness. I was aware of controversy surrounding a deep breathing exercise video for COVID patients published on YouTube by a doctor. This had been widely circulated on social media, having been personally recommended by a celebrity, but serious concerns had been expressed by medical experts about patient safety (Saner, 2020). Though deep breathing exercises may be helpful generally for recovering COVID patients (Lien, 2020), I needed to adopt a cautious approach given that some who may potentially use the resource I was creating may be suffering from breathlessness.

In any case, it seemed unnecessary to bring potentially anxious and fearful patients awareness to any symptom they may be experiencing. Whilst I was aware of this being the approach adopted in some medically-oriented relaxation scripts (Davenport, 2016; Inner Health Studio, 2008-2018; Unlock Your Life, 2015), my test version being an example, I felt that Pärt's music allowed a different approach to be taken. The talk-over, which had been both medically and healing oriented in the test version, became more exclusively healing oriented and much simpler in the revised version with Pärt's music. This new version allowed space for the music to be more fully experienced as co-therapist or even primary therapist in the process, with the potential for a positive impact on patients' breathing and

other symptoms without the need for words. My use of Pärt's music in this way was affirmed when a recovering COVID patient who tested the resource reported how relieved she felt that breath had not been mentioned, although she did experience her breathing to be deeper in a helpful way afterwards. This she attributed to the music.

MUSIC BREATHING

One of the first GIM therapists to use Pärt's *Spiegel im Spiegel* (1978) was Körlin, in the Music Breathing method he developed (2019a). This is an important specialist GIM method developed for stress related conditions where there is a persistent dysregulation of the Autonomic Nervous System; for instance, in PTSD, pathological grief reactions, the traumatising impact of some physical diseases and existential crises. In Music Breathing, the music is used to support patient's breathing to become centred lower in the body with a decreased breathing volume, which serves to regulate the level of arousal. Music Breathing is a systematic GIM method implemented in stages, the process assisted by verbal explanation, specialised relaxation inductions and patients drawing mandalas of their breathing volume (Körlin, 2020).

COVID-19 patients may themselves be experiencing significant stress as well potentially as breathlessness. For patients generally recovering from COVID-19, deep breathing can help restore diaphragm function, increase lung capacity and potentially lessen feelings of anxiety and stress and improve sleep quality (Lien, 2020). For those suffering from breathlessness, relaxed deep breathing that is slow and gentle and uses as little effort as possible, akin to that fostered in Music Breathing, is recommended (Association of Chartered Physiotherapists in Respiratory Care, 2011a, 2011b). This makes the kind of music used in Music Breathing potentially suitable for COVID patients (although I had elected not to verbally encourage deep breathing as discussed above).

The pieces in the Music Breathing music pool developed by Körlin (2019b) are categorised according to their arousal and modulation (change/development) levels, where music with lower levels of these are used first in the process. From a Music Breathing perspective, Pärt's piece is assessed to be of low levels of both arousal and modulation (Körlin, 2019b). The music's suitability for Music Breathing can be associated with its formal characteristics, including performance elements such as tempo, which needs to be fairly slow. [2] These same characteristics made the music and performance I chose suitable for my COVID project. Thus, for example, Pärt's music had the potential to help regulate and deepen patients' breathing and state of relaxation, as is clinically desirable (whether or not the patient is experiencing breathlessness), even though no verbal interventions of the type employed in Music Breathing would be used.

CHARACTERISTICS OF THE MUSIC CHOSEN

The simple structure of the Pärt's music made it appropriate in many different ways. From a GIM perspective, the music can be categorised as 'supportive and safe' (Bonde & Wärja, 2014) and its mood identified as 'quiet, tranquil, lyrical, serene and soothing' according to Hevner's mood wheel, which is used in GIM music analysis (Wigram et al., 2002). For COVID patients who may be fatigued and feeling

[2] Körlin (2019b) uses the original violin and piano version in a recording lasting 10:24, the version I use for cello lasting 10:15.

unwell generally, and who may be unable to 'take in' and engage productively with the more stimulating and complex music often used in GIM, Pärt's undemanding piece seemed especially suitable as a potentially palatable, nurturing and healing musical 'medicine'.

Written in 1978, the piece is an early example of the composer's tintinnabular style, which always combines two different types of voice (Hillier, 1997). One voice – in *Spiegel im Spiegel,* the cello - moves diatonically in stepwise motion. The other tintinnabular voice – in this piece, the piano – is arpeggiated, with the second tone of each arpeggio always a member of the F major tonic chord. The piano part also includes various other sustained tonic chord tones, sounded in the low, middle and upper registers of the instrument. These sustained sounds have a gentle bell-like (or tintinnabular) quality (Figures 1 & 2). [3] The tonic chord is thus omnipresent throughout, giving the music a closed-in quality that can be associated with the sense of unity or oneness the composer intends in his tintinnabular music (Hillier, 1997).

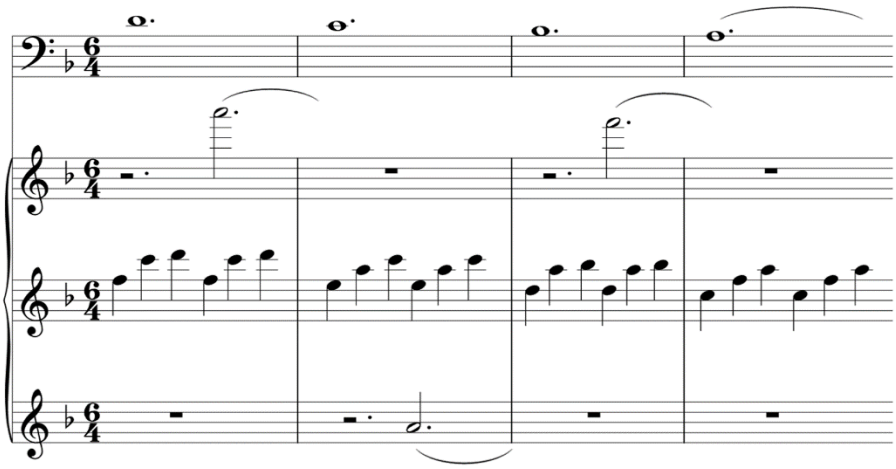

Figure 1: bars 42-45 (cello and 3-stave piano part)

Simultaneously countering and complementing this closed-in quality of the music are elements that give it a more suspended, open quality. Examples are the arpeggiated chords that begin (and end) the piece in the piano. These are second inversion tonic chords, which at the start of the composition are only fully grounded in the second bar with the sounding of the tintinnabular octave tonic F's in the bass (Figure 2):

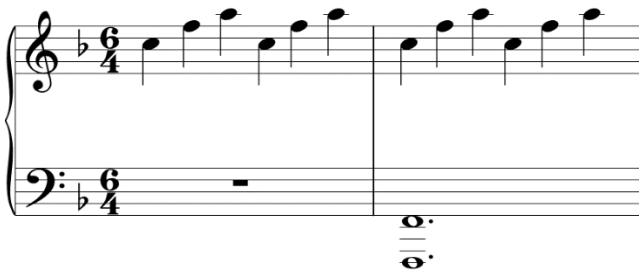

Figure 2: bars 1-2 (piano)

[3] All the music examples included are adapted from Pärt, 1978.

The many sustained soundings of the tone A below middle C in the cello (Figures 3 & 4), this being the third and not the root of the tonic chord, add to the music's slightly suspended, open quality. Whilst there is no traditional development of the material, there is a sense of the music's gradually unfolding as its pitch range extends in the cello part. The embodied inner space (Lawes, 2017) generated by the music opens-up little by little as the cello's slow moving scales alternately rise and fall in pitch. This is where I believe the music in GIM has the potential to create a bounded sense of inner, psychic or mental space that can be associated with the subtle, emotional or dream body as described in the yoga and meditation traditions of the East (Lawes, 2017; Wilber et al, 2008). This level of embodiment is grounded in the experience of the physical body at the level of the Core Self as Stern describes (2000). Thus, in Pärt's piece, the experience of embodiment and holding, which can be associated with the physically felt resonance of the cello phrases, forms the basis for the emotional and imagery-based dimensions of subtle level embodiment experienced and for an associated sense of inner space that is at once physically and mentally/emotionally felt.

The first pair of cello phrases are comprised of two tones (Figure 3):

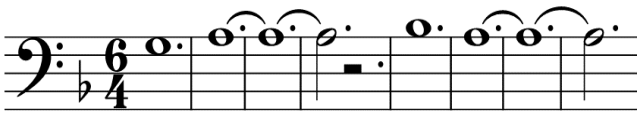

Figure 3: bars 4-11 (opening cello phrases)

Every new pair of cello phrases includes an additional tone, the music steadily unfolding and expanding in this way. The passage of music in Figure 4, for example, which comes from near the end of the composition, features two seven-tone scales followed by the first of two eight-tone scales. The music's quality of opening-out, as unfolds over the course of the composition, balances its closed-in quality. The latter is not only generated by the omnipresent tonic as discussed above but also by the alternation of upward and downward moving cello phrases, which always come to rest on the same sustained tone A. This creates a sense of the endless reflections suggested by Pärt's title *Spiegel im Spiegel*, which translates as 'mirror in the mirror' or 'mirrors in the mirror'.

Whilst the music may be very simple and include many reassuring elements of repetition, the gradual extension of the material in the cello part has, I believe, the potential to hold and engage the listener where exact repetition of the material would not. In the listener's engagement, I consider aspects of performance quality that defy musical notation, or are inarticulate as Ehrenzweig describes (Ehrenzweig, 1953, 1967), to have great importance. Examples are moment-by-moment micro-changes in volume, vibrato and timbre. These subtle form-elements can be considered to be essential aspects of the music's structure. They serve both to help hold the listener in the present moment experience of the music, and at the same time enable the listener to sense when each scale phrase is coming to an end.

Each phrase is thus effectively performed as a single unfolding whole within the context of the greater whole of the complete composition. In part as a result of the employment of these inarticulate

performance elements in helping shape the music's unfolding[4], the piece is, I believe, experienced to be an indivisible whole, an integrated totality that is more than the sum of the separate tones and phrases that comprise the music at the level of the score (Bohm, 1980; Ehrenzweig, 1967; Lawes, 2017; Stern, 2004). The patient's experience of unfolding wholeness in this sense, and associated with it the patient's experience of feeling deeply held as the cello phrases gradually extend, may have especial importance in contributing to clinically desirable outcomes such as a deepening of the breathing, a slowing of pulse and achieving a state of relaxation.

The experience of the 'dynamic opening-closing' (Lawes, 2017, p. 281) of the music's unfolding as an integrated whole, in which the music's closed-in qualities are balanced by its more open and expansive qualities, may not only have physiological benefits for the patient. I believe that the music also has the potential to support patients psychologically, emotionally and spiritually during this period (that of the COVID pandemic) of great uncertainty and fear, of an unknown future, of isolation and disconnection, of change, disorientation and disempowerment, of loss and grief, both individual and collective.

Rather than contain and transform the turbulence of anxiety and emotion that patients may be experiencing, as a Bonny Method of GIM music programme might do through matching the intensity and range of emotion, Pärt's deeply peaceful and stable music in its quiet way does something potentially more manageable yet also healing and transformative. *Spiegel im Spiegel* does not chart a dramatic emotional trajectory, as much of the music used in GIM does. At the same time, the many fleeting moments of micro-tension and their resolution, which are integral to the deeply felt unity of the music's tintinnabular style, may be important in the soothing of inner tension, whether this be bodily or emotionally felt, or both. This aesthetically contained and transformed micro-tension, involving the patterning of tension and release (Rose, 2004), is resonant musically in bars 42 and 44, for example. It occurs between the sustained cello tone on the one hand and the second and fourth arpeggiated (tintinnabular) piano tones on the other hand (Figure 1).

Finally, I suggest, Pärt's piece is also resonant of the 'slowing down' and simplification of living that many have been experiencing under lockdown, the music creating an introspective atmosphere in which the pure sonority, simple beauty and presence of the music dominate. In this way, the music not only potentially provides an inwardly felt 'place' in which to rest, experience healing and feel nurtured, but perhaps even an opening to transcendence. This is as the composer himself intended in his tintinnabular music, developed as a result of mystical experiences with chant music (Hillier, 1997).

TALK-OVER

Following an introduction to the experience, the patient is supported to get comfortable, begin to relax and connect with the music as it starts (COVID-19 Guided Imagery and Music Self-Help, 2020a). After the opening four bars of the music, the talk-over itself begins (see Appendix A for a full written version of the introduction and talk-over). The patient is first encouraged to trust the body's own healing process, allowing it the time that may be needed. Following a simple body-scan the script then

[4] Ehrenzweig (1967) describes the unconscious form-discipline employed by performers in their use of vibrato and rubato, for instance, so that a composition is performed as an integrated whole and not in a fragmented way as separate tones and phrases played one after the other.

suggests the patient imagine healing light being taken into the body so that it can bring what is needed. This is first to the head and mind. Next comes the upper respiratory tract, where infection is likely to cause many of the most common early symptoms of the disease. From here the focus moves to the lungs where more serious problems may occur later, and finally to anywhere else in the body that the patient feels healing is needed.

Even for those who only experience relatively mild symptoms, these symptoms can be quite variable - ranging from headaches and fatigue, to dry cough, to fever and chills, to breathlessness, to nausea, vomiting and diarrhoea, to aches and pains in various parts of the body (Centers for Disease Control and Prevention, 2020). Because of this variation and because GIM research shows that patients image in different ways (Bruscia et al, 2005; Bush, 1995), the talk-over is designed to guide the patient's experience so that it remains focused on the body-oriented healing imagery but without over prescribing the detail of this. The idea is for the patient to become imaginatively engaged in the process according to their own needs and style of imaging, involving both the conscious and unconscious mind. Thus, for example, the patient is encouraged to choose the colour of the light (suggesting a conscious choice) and let it change at any time if needed (suggesting a colour change that is more unconsciously generated). The introduction to the talk-over prepares the ground, describing how imagery experiences may occur in a number of different modalities, and even in a number of modalities simultaneously.

RELATIONSHIP BETWEEN THE MUSIC AND THE TALK-OVER

The talk-over is also designed to align with the music, the voice and cello being heard in interplay. Alternate phrases of the talk-over feature the refrain 'soothing, calming and relaxing' so that this is frequently repeated. In this repetition and in other ways, the type of language and grammar used along with the pacing and musical qualities of my spoken voice reflect GIM induction and guiding technique (Bruscia, 2015). I carefully edited out the sound of my breathing during the talk-over, given COVID patients with breathing difficulties may be hyper-vigilant to this.

Figure 4 illustrates the interplay of the talk-over and cello phrases. The talk-over at this point suggests that the patient allow the healing light to move into the throat and airways having previously been in the head. This spoken intervention occurs during a sustained A in the cello (bars 61-63) as do all the spoken interventions except one. The structure of the music makes this possible and means that the spoken and cello 'voices' do not compete but cooperate effectively as co-therapists[5]. The bodily-felt resonance of the cello phrase that follows (bars 64-70), whilst it may begin on a low Bb and rise in pitch, in my experience works well to support the transition of the light lower down into the body. The refrain 'soothing, calming and relaxing' on the next sustained tone A in the cello (bars 70-72) is intended to reinforce any healing imagery the patient is experiencing, supporting the patient to remain focused and engaged, ready for the experience to develop further as the cello takes the lead once again in the following bars.

[5] A very subtle but important aspect of this cooperation is in the articulation of the voice not coinciding with the articulation of the sustained tonic chord (tintinnabular) tones in the piano part (see text above describing Figures 1 and 2). I carefully edited the recording so that the articulation of the voice is heard either momentarily before or after the piano tones where possible.

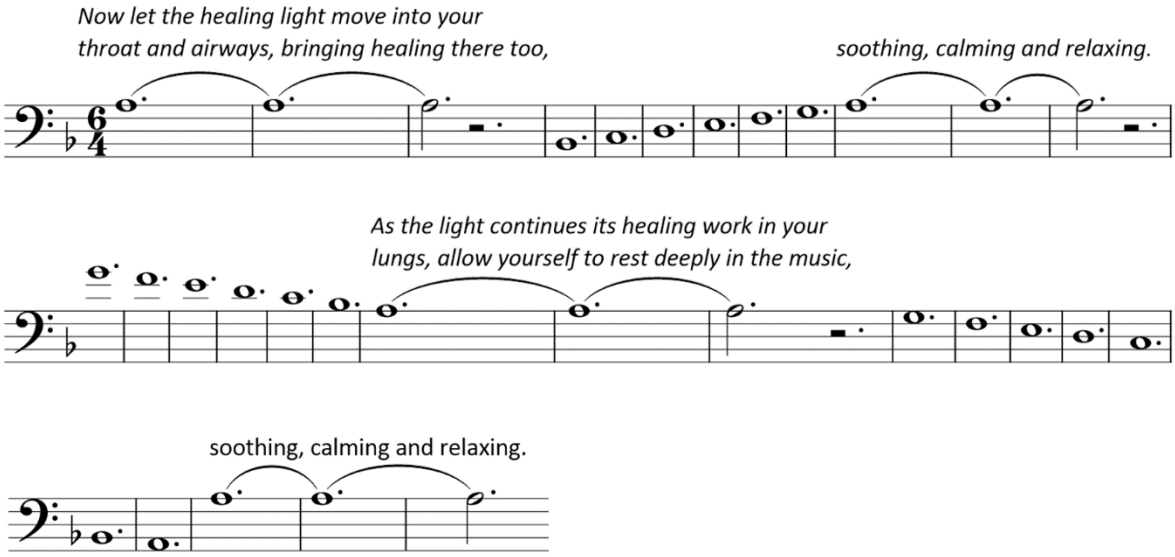

Figure 4: bar 61-91 illustrating the interplay of the talk-over and cello

The verbal intervention that follows illustrates how the patient is encouraged to connect with the music not simply as co-therapist but even as the principal therapist in the process (Bruscia, 2002; Lawes, 2016). The talk-over suggests that whilst the work of the healing light continues in the lungs, the area of the body potentially the most seriously affected by the disease, the patient rest deeply in the music. The intention is for the patient to feel deeply held, open to the maximum extent to what the music has to offer as the cello slowly descends in pitch. Here the music, I suggest, has a special potential to support the deepening of the patient's state of relaxation and breathing, along with a slowing of pulse (Körlin, 2020).

SAFETY

A special consideration in developing a generic online resource intended for the general public was patient safety. The Bonny Method of GIM has known contra-indications and risks that the therapist takes account of in assessing patient suitability (Bruscia, 2015), with MI methods potentially more suitable for some people. However, the guided imagery self-help resources available on the internet do not generally provide information about who may and may not benefit, nor about contra-indications and risks.

With my knowledge and experience as a GIM therapist, I felt it important to address safety and risk, but to do this in a way that did not unnecessarily alarm patients. I needed to take a responsible approach whilst recognising that ultimately it is every individual's decision whether to use the resource, the experience they have beyond my control and responsibility. I decided to include suitable guidance in the introduction to the talk-over (see Appendix A) supplemented by written information incorporated in the YouTube video description (see Appendix B). The rationale for and nature of the intended experience is outlined, and the importance of following medical advice stated especially if a patient's condition worsens. I acknowledge that many people are experiencing increased anxiety due

the impact of the epidemic and that guided imagery interventions may be helpful (as research suggests). I add:

> However, you are not recommended to use this recording if you have more serious long-term mental health issues, requiring support from a psychiatric team member, for example. Or at least you are advised not to use the recording without seeking advice from a qualified mental health practitioner first. Guided imagery methods may be helpful as research suggests, but not necessarily in this form and not without the support of a trained therapist (COVID-19 Guided Imagery and Music Self-Help, 2020, YouTube written description).

I also advise that patients can stop the experience at any time should they wish, the intension being to empower any more psychologically vulnerable individuals struggling with the experience in some way to disengage from it.

Directed music imaging, as the most contained and tightly structured GIM method, guides the patient to have a focused experience that Bruscia characterises as outcome specific (Bruscia, 2015). In the case of my COVID resource this involves the imagery of healing light being taken through the body. The talk-over does not encourage the freer and potentially much more wide ranging exploration of consciousness and of outcomes that occurs in Bonny Method work, for instance.

Pärt's simple, stable and predictable music is as important as the talk-over in helping keep the experience a simply contained one. His piece has no significant dynamic change (except in the very subtle ways described), has no development, secondary themes/or other material and none of the complex, multi-layered structure and timbral variety of the orchestral music typically used in GIM. That the material does not develop and has the tintinnabular holding qualities described above, makes it suitable to support patients having a simple focused experience as is the intention. This type of experience is that of a single image in GIM terms (an unfolding body-based one), and contrasts with the complex, multi-faceted, emotionally rich and varied narrative of a Bonny Method of GIM 'music travel', which typically features many different images and different types of imagery.

Other ways in which I present and facilitate the experience with the intention of making it suitable and safe as a generic online resource for COVID patients, who may have little or no experience in GIM or anything similar, include:

- patients being encouraged to close their eyes, but to feel able to open them if they feel they need to, in which case a simple video image is provided as a possible focus.
- patients being advised not to lie on their backs as is usual in GIM. This is contra-indicated for COVID-19 patients because it blocks the airways which need to be kept open.
- the experience being kept deliberately short.
- there being no relaxation induction before the music begins which might generate an unnecessarily deeply altered or non-ordinary state of consciousness.
- there being no excessively long 'windows' between the verbal interventions, these latter occurring at regular, predictable intervals aligned with the music.

When I sent a test version of the resource to a number of experienced GIM and other therapists and researchers in Europe and the USA, I invited feedback including about patient safety. No concerns were raised or even comments made about this.

TRANSLATIONS

When I shared the final published version of the resource with GIM colleagues via email, I suggested that it would be relatively straight forward to create versions in different languages should anyone be interested in that. I received responses from Chinese, Greek, Italian, German, Japanese, Korean and Spanish therapists all interested in creating a version in their own language. This involved my sending the therapists concerned the script of the talk-over and the YouTube written information for translation. Each person recorded the talk-over in their own language after which I edited and combined all the material using video editing software. The new versions were then uploaded to the same YouTube channel as the original, the Mandarin version also to a Chinese equivalent:

- Chinese (Cantonese) version translated and recorded by Angela Shum (COVID-19 Guided Imagery and Music Self-Help, 2020b)
- Chinese (Mandarin) version translated by Angela Shum, edited by Xijing Chen and recorded by Ming Liu (BiliBili, 2020; COVID-19 Guided Imagery and Music Self-Help, 2020f)
- German version translated and recorded by Gert Tuinmann (COVID-19 Guided Imagery and Music Self-Help, 2020c)
- Greek version translated and recorded by Evangelia Papanikolaou (COVID-19 Guided Imagery and Music Self-Help, 2020d)
- Italian version translated and recorded by Gabriella Giordanella Perilli and Marika Grieco (COVID-19 Guided Imagery and Music Self-Help, 2020e)
- Japanese version translated and recorded by Motoko Hayata (COVID-19 Guided Imagery and Music Self-Help, 2020g)
- Korean version translated and recorded by Min-Jeong Bae (COVID-19 Guided Imagery and Music Self-Help, 2020h)
- Spanish version translated and recorded by Patricia Ortega (COVID-19 Guided Imagery and Music Self-Help, 2020i)

I also created a YouTube playlist that includes all the different versions (Guided Imagery and Music [GIM] COVID-19 Self-Help Resources, 2020).

CONCLUSION

This report describes my creation of a COVID-19 GIM resource, discussing the type of GIM experience it is intended to be, the qualities and suitability of the music used, the talk-over and its relationship with the music, and special concerns such as breathing and safety. There appears to be an emergent trend in GIM to produce resources of this type, if more usually for specific patient populations. My hope is that other GIM therapists may consider the merits of developing this type of recorded resource. The COVID epidemic has brought both challenges and opportunities and these may impact not only

on short-term developments in the practice of GIM, but perhaps also in the longer-term developments as well. I hope that my response to the immediacy of the COVID epidemic may also be a contribution to longer-term developments in GIM.

Finally, whilst my resource is intended for COVID patients with mild to moderate disease, feedback suggests that people without the disease or symptoms of it may also potentially find the video helpful as a general wellbeing resource. I plan eventually to create a modified version that is not COVID specific and possibly formally research its effectiveness. This, however, is for the future.

ACKNOWLEDGEMENT

With gratitude to those who translated and recorded the talk-over as cited above and to those listed in Appendix B who generously gave feedback on test versions of the resource. Thanks also to Leonhard Roczek for allowing me to use his very fine recorded performance of *Spiegel im Spiegel*.

REFERENCES

Association of Chartered Physiotherapists in Respiratory Care (2011a). *How to cope with being short of breath - breathing exercises* [fact sheet] https://www.acprc.org.uk/Data/Publication_Downloads/GL-02HowtocopewithbeingSOB-breathingex(1).pdf?date=10/05/2020%2012:08:43

Association of Chartered Physiotherapists in Respiratory Care (2011b). *The active cycle of breathing techniques* [fact sheet] https://www.acprc.org.uk/Data/Publication_Downloads/GL-05ACBT(1).pdf?date=10/05/2020%2012:08:43

Bohm, D. (1980). *Wholeness and the Implicate Order*. Routledge and Kegan Paul.

Bonde, L. O. (2005). *The Bonny Method of Guided Imagery and Music (BMGIM) with cancer survivors: A psychosocial study with focus on the influence of BMGIM on mood and quality of life*. [Doctoral dissertation, Aalborg University]. http://www.wfmt.info/Musictherapyworld/modules/archive/dissertations/pdfs/Bonde2005.pdf

Bonde, L. O., & Wärja, M. (2014). Music as co-therapist: Towards a taxonomy of music in therapeutic music and imagery work. *Journal of Music and Medicine*, (6)2, 16-27.

Bonny, H. L., & Savary, L. M. (1990). *Music & your mind: Listening with a new consciousness*. Station Hill Press. (Original work published 1973)

Bruscia, K. (2002). The boundaries of Guided Imagery and Music and the Bonny Method. In K. Bruscia & D. E. Grocke (Eds.), *Guided Imagery and Music: The Bonny method and beyond* (1st edition, pp. 37-61). Barcelona Publishers.

Bruscia, K. (2015). *Notes on the practice of GIM*. Barcelona Publishers.

Bruscia, K., Abbott, E., Cadesky, N., Condron, D., Hunt, A., Miller, D., & Thomas, L. (2005). A heuristic-collaborative analysis of Imagery-M: A music program used in Guided Imagery and Music. *Qualitative inquiries in music therapy* (vol. 2). Barcelona Publishers. http://www.barcelonapublishers.com/QIMTV2/QIMT20052(1)Brusciaetal.pdf

Bush, C. A. (1995). *Healing, imagery and music: Pathways to the inner self*. Rudra Press.

Centers for Disease Control and Prevention (2020). *Symptoms of coronavirus* https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

COVID-19 Guided Imagery and Music Self-Help (2020a, April 22). *COVID-19 Guided Imagery and Music (GIM) Self-help resource* [video]. YouTube. https://www.youtube.com/watch?v=ssKIjeGY_Lg

COVID-19 Guided Imagery and Music Self-Help (2020b, April 30). *COVID-19 音樂引導想像 (GIM) 自助資源-粵語 (Cantonese).* [video]. YouTube. https://www.youtube.com/watch?v=uFz_WDlYpeY

COVID-19 Guided Imagery and Music Self-Help (2020c, May 2). *COVID-19 "Guided Imagery and Music" (GIM) Selbsthilferessource.* [video]. YouTube. https://www.youtube.com/watch?v=eU_IvSkceSQ

COVID-19 Guided Imagery and Music Self-Help (2020d, May 3). *Η μουσικοθεραπεία "Guided Imagery & Music" (GIM) ως μέσο αυτοβοήθειας στη νόσο COVID-19.* [Video]. YouTube. https://www.youtube.com/watch?v=DvHVqOp7b-0

COVID-19 Guided Imagery and Music Self-Help (2020e, May 6). *Rilassamento e benessere con immagini e musica per pazienti affetti da COVID-19.* [Video]. YouTube. https://www.youtube.com/watch?v=_IrocnCl-5g

COVID-19 Guided Imagery and Music Self-Help (2020f, May 7). *COVID-19 音樂引導想像 (GIM) 自助資源-普通話 (Mandarin)* [Video]. YouTube. https://www.youtube.com/watch?v=B9g0Je3NHLM

COVID-19 Guided Imagery and Music Self-Help (2020g, May 25). *COVID-19 音楽イメージ療法 (GIM: Guided Imagery and Music) によるセルフヘルプ用ビデオ* [Video]. YouTube. https://www.youtube.com/watch?v=520q-upVnnE

COVID-19 Guided Imagery and Music Self-Help (2020h, June 23) *코로나19 대처를 위한 심상음악 기반의 자기돌봄* [Video]. YouTube. https://www.youtube.com/watch?v=HGn40G0sshM

COVID-19 Guided Imagery and Music Self-Help (2020i, July 1). *Meditación de Imaginación Guiada con Música (GIM) de autoayuda para COVID-19* [Video]. YouTube. https://www.youtube.com/watch?v=0ZPXbp2Ixek

Davenport, L. (ed.) (2016). *Transformative imagery: Cultivating the imagination for healing, change, and growth*. Jessica Kingsley Publishers.

Ehrenzweig, A. (1953). *The psychoanalysis of artistic vision and hearing*. Routledge and Kegan Paul Ltd.
Ehrenzweig, A. (1967). *The hidden order of art: A study in the psychology of artistic imagination.* University of California Press.
GIM resources (2020a, April 3) *Online GIM using Zoom.us.* [Video]. YouTube. https://www.youtube.com/watch?v=zC8Dqf5o0Uw
GIM resources (2020b, April 13) *Zoom security and top tips for delivering online. GIM* [Video]. YouTube. https://www.youtube.com/watch?v=EZg2lelVxlM
Guided Imagery and Music (GIM) COVID-19 self-help resources (2020) [playlist]. YouTube. https://www.youtube.com/playlist?list=PL3RSWJ60NEQAGklk01eK9pYK9hbB9PJ9V
Grocke, D., & Moe, T. (Eds.). (2015). *Guided Imagery & Music (GIM) and Music Imagery methods for individual and group therapy*. Jessica Kingsley Publishers.
Grocke, D. E. (2019). Mixed methods in GIM research. In D. E. Grocke (Ed.), *Guided Imagery and Music: The Bonny method and beyond* (2nd ed.). Barcelona Publishers.
Hertrampf, R-S. (2017). *"Keyboard of life": Music therapy in psycho-oncology – guided imagery and music (GIM) in curative and early palliative treatment for women with breast cancer or gynaecological cancer – a mixed methods study.* [Doctoral dissertation, Aalborg University]. https://doi.org/10.5278/vbn.phd.hum.00075
Hillier, Paul (1997). *Oxford studies of composers: Arvo Part.* Oxford University Press.
Inner Health Studio (2008-2018). *Relaxation for healing: Guided Imagery for illness recovery*. https://www.innerhealthstudio.com/relaxation-for-healing.html
Körlin, D. (2019a). Music Breathing. In D. E. Grocke (Ed): *GIM: The Bonny method and beyond* (2nd ed.). Barcelona Publishers.
Körlin, D. (2019b). *Music breathing: Music pool with arousal and modulation levels*. Unpublished Training Manual.
Körlin, D. (2020). *Silent and music breathing: Procedures and inductions.* Unpublished Training Manual, revised version, April 15, 2020.
Lawes, M. J. (2016). Perspectives on the real, the imaginary and the music in GIM. *Journal of the Association for Music and Imagery,* 15, 93-124.
Lawes, M. (2017). Music as dynamic experience of unfolding wholeness in Guided Imagery and Music (GIM): A psychoanalytic, musical, transpersonal and trans-scientific paradigm. *Approaches: An Interdisciplinary Journal of Music Therapy, Special Issue 9*(2), 275-299. http://approaches.gr/wp-content/uploads/2017/12/8-Approaches-9-2-2017-lawes-a20171222.pdf
Leonhard Roczek (2014, August 13) *Spiegel im Spiegel for Cello and Piano (Arvo Pärt)* [Video]. YouTube. https://www.youtube.com/watch?v=FZe3mXlnfNc
Lien, P. (2020). Coronavirus recovery: Breathing exercises. *Johns Hopkins Medicine*. https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus/coronavirus-recovery-breathing-exercises
McKinney, C. (2019). Quantitative research in Guided Imagery and Music: A review. In D. E. Grocke (Ed): *Guided Imagery and Music: The Bonny method and beyond* (2nd ed.). Barcelona Publishers.
Messell, C., & Pedersen, K.Ø. (2019). Music mindfulness. www.music-mindfulness.dk
Pärt, A. (1978). *Spiegel im Spiegel for violoncello and piano*. Universal Edition.
Pedersen, K.Ø., & Sanfi, I (2018). MICO: Music imagery in child oncology. https://www.micostudy.com/
Rose, G. J. (2004). *Between Couch and Piano: Psychoanalysis, music, art and neuroscience.* Brunner-Routledge.
Saner, E. (2020, 9 April). Do breathing exercises really work? UK doctors on how to protect against coronavirus – and manage symptoms. *The Guardian.* https://www.theguardian.com/lifeandstyle/2020/apr/08/from-vitamin-c-to-breathing-exercises-doctors-on-what-you-should-really-do-for-your-health-right-now#maincontent
Sanfi, I. (2012). Et specialdesignet musikkoncepts betydning for general velbefindende og helse hos børn med kræft i kemoterapi. In G. Trondalen & K. Stensæth (red.), *Barn, Musikk og Helse*. NMH-publikationer 2012(6), 101–122.
Sanfi, I., & Christensen, E. (2017). Perspectives on music imagery and complex chronic pain. *Approaches: An Interdisciplinary Journal of Music Therapy, Special Issue 9*(2), 233-245. http://approaches.gr/wp-content/uploads/2017/12/4-Approaches-9-2-2017-sanfi-a20171222.pdf
Sanfi, I. (2019). Use of technology in GIM therapy. In D. Grocke (Ed.), *Guided Imagery and Music: The Bonny method and beyond* (2nd ed., pp. 741-767). Barcelona Publishers.
Self-care resources for GIM therapists. (2020, March 28). *Videos* [YouTube channel]. from https://www.youtube.com/channel/UCZ0hlzpIlEYfx62NPTv-tXQ/videos
Stern, D. (2000). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology.* Basic Books.
Stern, D. (2004). *The present moment in psychotherapy and everyday life.* WW Norton and Co.
Torres Serna, E. (2015). *Effectiveness of GRPMI with fibromyalgia patients*. [Doctoral dissertation, Aalborg University]. https://doi.org/10.5278/vbn.phd.hum.00001
Unlock Your Life (2015, 7 December). *Cold and flu healing hypnosis: Guided meditation for illness recovery.* [Video]. YouTube. https://www.youtube.com/watch?v=CK7Y6mTjtrc
Wärja, M. (2018). *Arts-based psychotherapy for women recovering from gynecological cancer: A randomized trial evaluating the effects on psychological outcomes*. [Doctoral dissertation, Aalborg University]. https://doi.org/10.5278/vbn.phd.hum.00090
Wilber, K., Patten, T., Leonard, A., & Morelli, M. (2008). *Integral Life Practice.* Integral Books.
Wigram, T., Pedersen, I. N., & Bonde, L. O. (2002). *A comprehensive guide to music therapy: Theory, clinical practice, research and training.* Jessica Kingsley Publishers.
Young, L. (2019). Qualitative research in individual Guided Imagery and Music (GIM). In D. E. Grocke (Ed.), *Guided Imagery and Music: The Bonny method and beyond* (2nd ed.). Barcelona Publishers.
新冠肺炎音乐引导想象(GIM)自助資源. (2020, May 8). [Video]. BiliBili. https://www.bilibili.com/video/BV1Ng4y167wK/

APPENDIX A: INTRODUCTION AND TALK-OVER (COVID-19 GUIDED IMAGERY AND MUSIC SELF-HELP, 2020)

Welcome to this Guided Imagery and Music relaxation and healing oriented experience developed for those with mild to moderate covid-19. The intension is to help you relax and engage your imagination supported by music as this has the potential to be a powerful ally in the healing process.

You'll be guided to imagine taking healing light into your body so that it can go to the places it's needed to support your body's own healing process. You'll be able to imagine this in your own way which for some people may be a very visual experience and for other people more bodily felt, intuitive or focused on the music, for example. Or your experience may involve all of these things.

The music used is a serene and soothing piece of classical music for cello by the Estonian composer Arvo Pärt, details of the music listed in the YouTube description of this video should you want to listen to the music again.

The experience is intended to complement conventional medical treatment. This means it's important for you to always follow medical advice and seek help if your condition worsens. Many people are experiencing increased anxiety at the moment and guided imagery and music can be very helpful for that, though you're not recommended to use this recording if have more serious long-term mental health issues, for example requiring support from a psychiatric team member. For everybody, it's important to be aware that you can stop the experience at any time should you wish.

When you're ready to start, a good way to listen to the recording is using headphones or earbuds. Make sure that you won't be disturbed by phone calls or other people for the next 15 minutes. Get in a comfortable position where your body feels supported including your head, taking account of any medical advice you may have been given. It's good to be in a position where your lungs can be as open as possible and avoid lying flat on your back. Propping yourself up with pillows maybe an option. If you feel uncomfortable at any time, allow yourself to move into a more comfortable position.

As we move into the relaxation now and if you feel comfortable to do so, close your eyes, knowing that you can open them at any time if you need to, in which case you may like to look at the video image accompanying the recording on your device. Be aware of whatever you're sitting or lying on - letting yourself sink down into the support it gives your body. Let yourself relax as the music begins now.

……

Know that you can help your body heal by relaxing in this way:
Your body knows what to do to bring healing but also needs time, maybe quite a lot of time.
Check through your body now noticing how you feel - in your face and head,
in your upper body, arms and hands,
down into your legs and feet.
Now begin to sense that you are in the presence of healing light.
The light can be whatever colour you would like it to be, so as to bring you what you most need,
and the colour can change at any time if that's needed.
Let this healing light begin its work by bathing your face and head, bringing what they need,
letting the music also help with this, soothing, calming and relaxing.
Bringing healing not only physically but also emotionally.
Now let the healing light move into your throat and airways, bringing healing there too,
soothing, calming and relaxing.
As the light continues its healing work now in your lungs, allow yourself to rest deeply in the music,
soothing, calming and relaxing.
Finally, letting the healing light move to any other places in your body where you feel that healing is needed,
Soothing, calming and relaxing.

……

Now the music has finished, let the healing light gradually come out of your body, knowing that it is always there if you need it again, and knowing that you can use this recording again should you wish.

When you're ready, you can open your eyes taking all the time that you need - or you can allow yourself to drift off to sleep, removing your headphones and making sure you're in a suitable position, knowing your body will continue to work hard to bring healing whether you are awake or asleep.

APPENDIX B: WRITTEN DESCRIPTION ON YOUTUBE (COVID-19 GUIDED IMAGERY MUSIC SELF-HELP, 2020)

This Guided Imagery and Music (GIM) relaxation and healing oriented experience has been developed for those with mild to moderate symptoms of COVID-19, the experiential part beginning at 3:08 after an introduction.

The experience is intended to complement conventional medical treatment, through supporting your body's own healing process and through providing psychological and emotional support. It cannot cure COVID-19 so it is important that you always follow medical advice and seek help if your condition worsens.

The music used is a serene and soothing piece of classical music for cello by the Estonian composer Arvo Pärt, detailed below, where it is as if the music breathes gently but deeply, holding the listener in its embrace.

Research suggests that for various medical conditions, GIM and other types of guided imagery may help in managing stress, anxiety and depression, may have beneficial physiological effects, may help managing medical treatment and its side effects, and may help boost the immune system. This new recording has been created by an experienced GIM therapist, trainer and researcher in consultation with other experts in the field, based in existing knowledge, experience and research.

Many people are experiencing increased anxiety at the moment and guided imagery can potentially be helpful for this. However, you're not recommended to use this recording if have more serious long-term mental health issues, requiring support from a psychiatric team member, for example. Or at least you are advised not to use the recording without seeking advice from a qualified mental health practitioner first. Guided imagery methods may be helpful as research suggests, but not necessarily in this form and not without the support of a trained therapist.

For everybody, it is important to be aware that you can stop the experience at any time should you wish. It is also important not to use the recording while driving or operating machinery or when in other ways you need to remain alert to your environment: you may become very relaxed and even fall asleep.

This GIM self-help resource differs from GIM undertaken with a qualified therapist. As an evidence-based approach, GIM can potentially help with a wide range of psychological and emotional issues. Therapists are available worldwide: https://ami-bonnymethod.org/find-a-practitioner.

Music (used with the permission of Leonhard Roczek): https://www.youtube.com/watch?v=FZe3mXlnfNc
Arvo Pärt: Spiegel im Spiegel, version for Cello and Piano
Leonhard Roczek - Cello
Herbert Schuch - Piano
.....

GIM script created and recorded by Martin Lawes, UK based Health and Care Professions Council registered Music Therapist (HCPC - https://www.hcpc-uk.org/), Guided Imagery and Music (GIM) Therapist and Fellow of the Association for Music and Imagery (FAMI - https://ami-bonnymethod.org/), AMI endorsed GIM Primary Trainer, Director of the Integrative GIM Training Programme (https://www.integrativegim.org/)

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Stock footage provided by Videvo https://www.videvo.net

Ελληνική περίληψη | Greek abstract

Δημιουργώντας ένα μέσο αυτοβοήθειας βάσει της μεθόδου Guided Imagery and Music (GIM) για άτομα με ήπια ή μέτρια συμπτώματα της νόσου COVID-19

Martin Lawes

ΠΕΡΙΛΗΨΗ

Η παρούσα αναφορά πραγματεύεται τη δημιουργία ενός μέσου αυτοβοήθειας για τη νόσο COVID-19, το οποίο βασίζεται στη μέθοδο Guided Imagery and Music (GIM) και διατίθεται διαδικτυακά στο YouTube σε εννέα διαφορετικές γλώσσες. Η μέθοδος GIM, ως ένας εξειδικευμένος τομέας πρακτικής στη μουσικοθεραπεία, μπορεί να γίνει καλύτερα κατανοητή ως ένα εύρος μεθόδων. Το μέσο αυτοβοήθειας για τον κορονοϊό είναι ένα παράδειγμα «κατευθυνόμενης μουσικής απεικόνισης», η οποία είναι μία μέθοδος GIM εστιασμένη στην έκβαση αποτελεσμάτων, και στην οποία γίνεται αφήγηση κειμένου ή νοερής απεικόνισης κατά τη διάρκεια μουσικής υπόκρουσης. Το συγκεκριμένο μέσο αυτοβοήθειας στοχεύει στην ενίσχυση της διαδικασίας αυτο-ίασης του σώματος σε ασθενείς με ήπια ή μέτρια συμπτώματα της νόσου, αλλά και στην παροχή ψυχολογικής και συναισθηματικής υποστήριξης. Εξετάζεται επίσης η καταλληλότητα της μουσικής που χρησιμοποιήθηκε, η οποία ήταν το έργο Spiegel im Spiegel του Pärt, καθώς και η αφήγηση και η συσχέτιση αυτής με τη μουσική. Τίθενται επίσης υπό συζήτηση και ορισμένοι προβληματισμοί που ήταν απαραίτητο να

ληφθούν υπόψη αναφορικά με τη δημιουργία ενός γενικού μέσου αυτοβοήθειας GIM το οποίο είναι διαθέσιμο διαδικτυακά για ασθενείς με κορονοϊό.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

Guided Imagery and Music (GIM), κορονοϊός (COVID-19), πηγή αυτοβοήθειας, κατευθυνόμενη μουσική απεικόνιση, αφήγηση, το έργο Spiegel im Spiegel του Pärt, αναπνοή συνδυασμένη με μουσική ακρόαση

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REPORT

Special Feature | Reports on online music therapy

Together in Sound: Music therapy groups for people with dementia and their companions – moving online in response to a pandemic

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ABSTRACT

Together in Sound is a partnership project between the Cambridge Institute for Music Therapy Research at Anglia Ruskin University (ARU) and Saffron Hall Trust, an arts charity based in rural Essex, England. Established in Autumn 2017, the project offers music therapy to people living with dementia and their companions and includes a practice-based research element. This co-authored report concerns the impact of the global COVID-19 pandemic on the project and presents the team's experience of moving music therapy sessions online in March 2020. Continuing online provided continuity, support, and ongoing connection for participants who, because of the national lockdown in the United Kingdom, were isolated in their own homes. After providing some context about the project, the report explores the challenges and benefits of online delivery of sessions with reflections from the Together in Sound team including potential implications for the future.

KEYWORDS

online music therapy,
people living with dementia,
caregiving couples,
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and raised in Taiwan, she studied Life Science as her undergraduate major. During her music therapy training, Chloe specialised in applying improvisation skills in placement. She joined the Together in Sound project from 2019, working with Claire Molyneux as a music therapy trainee and a co-therapist. [yutzu.musictherapy@gmail.com] **Katie McKinnon** is a recent music graduate with experience project managing community music and theatre projects across venues and festivals including the Edinburgh Festival Fringe. She is currently the Learning and Participation Coordinator for Saffron Hall Trust, facilitating relationships with local community and beyond with the world-renowned artists who visit Saffron Hall. Katie manages and administrates education and community projects including Together in Sound. [togetherinsound@saffronhall.com] **Helen Odell-Miller** OBE is a Professor of Music Therapy, and Director of Cambridge Institute for Music Therapy Research, Anglia Ruskin University. Her research and clinical work contributed to establishing music therapy as a profession; specifically to innovating approaches for older people living with dementia, and for adults with mental health issues. She is currently Principal Investigator for Homeside, a large five-country randomised controlled trial investigating music and reading for people living at home with their family carer. [helen.odell-miller@aru.ac.uk]

INTRODUCTION

Together in Sound (TiS) is a partnership project between the Cambridge Institute for Music Therapy Research (CIMTR) at Anglia Ruskin University (ARU) and Saffron Hall Trust, an arts charity based in rural Essex, UK. Established in Autumn 2017, the project offers music therapy to people living with dementia and their companions. It is an innovative collaboration between the arts sector and music therapy and includes placement opportunities for MA Music Therapy trainees and community experience for performing artists involved with Saffron Hall who attend training with the therapists prior to involvement in the project. The focus is on joint music-making and listening with a goal of supporting communication, relationships, and increasing quality of life through a collaborative group process. Working with people with dementia together with their companions brings a new dimension to music therapy practice in this field that has traditionally focused on working with the person with dementia on their own. The project is also the focus of the first author's current doctoral research in progress which is a narrative inquiry with practice-based arts-informed responses to explore the impact of the groups for participants. This report does not present the doctoral research but is an opportunity to share the team's experience of adapting the project to offer online sessions in response to the impact of the global COVID-19 pandemic. The report briefly outlines the context for group music therapy with people with dementia and their companions and provides an overview of Together in Sound. It then focuses on the adaptation required to offer online sessions including reflections from the project team.

CONTEXT

The Alzheimer's Society estimates that there are currently 885,000 people over 65 years old affected by dementia in the United Kingdom. This number is predicted to rise to 1.6 million by 2040 (Wittenberg et al., 2019). The health condition is marked by a progressive and irreversible decline in cognitive functioning, affecting day-to-day life and health. The recently published report from the Commission on Dementia and Music in the United Kingdom (Bowell & Bamford, 2018), comprehensively demonstrates the importance of music for people living with dementia and calls for more accessible services, research and training, to be available nationwide.

There is a growing body of evidence to show that music can unlock communication pathways for people living with dementia, even for those with advanced forms of the disease. Music therapy can help to: sustain relationships and share experiences (Baker et al., 2012; Brotons & Marti, 2003; Clair & Ebberts, 1997; Melhuish et al., 2019; Ridder, 2011;); minimise often-upsetting symptoms including agitation, anxiety and depression (Hsu et al., 2015; Raglio et al., 2008; 2010; Ridder et al., 2009; 2013; Vink et al., 2013; van der Steen et al., 2018); improve wellbeing and quality of life (Ahonen-Eerikäinen

et al., 2007), socially connect people, and reduce isolation (Svansdottir & Snaedal, 2006). In a community music therapy project, Rio comments on the opportunity for participants to "redefine their changing social identity" (Rio, 2018, p.3), a point which is supported by Dowlen (2018) who explored the idea of musicking as a means through which people living with dementia might facilitate active citizenship. Dowlen's research took place with the Manchester Camerata, a similar project to Together in Sound, where music therapy-based groups for people with dementia are facilitated by a music therapist and musicians from the Camerata. This type of collaboration between music therapists and professional musicians has not been well documented in the literature. It provides an additional position from which to consider the role of music in people's lives, where the therapist and musician work collaboratively to attend to health, wellbeing and aesthetic qualities of music making (Pugh, 2016).

Music therapy and couples with dementia

The importance of psychosocial interventions for people with dementia and their 'informal caregivers' is the subject of the systematic review by Rausch et al. (2017, p.591). They suggest further research is needed to "give insight in the relationship within the caregiving dyad, the impact of the dementia on this relationship, and the influence of the relationship on patients' and caregivers' quality of life, to further establish suitable psychosocial interventions for these caregiving dyads." In music therapy, there has been a growing interest in interventions for caregiving dyads. A feasibility study by Tamplin et al. (2018, p.1), "examined the acceptability of a 20-week therapeutic group singing intervention and quantitative research assessments." The study gathered qualitative interview data and conducted a thematic analysis which is reported on in Clark et al. (2018). The authors conclude that "such community-based, dyad-focused therapy interventions hold great potential to fill an important need for social connection and support, as well as addressing personal wellbeing and quality of life for community-dwelling people with dementia and their family caregivers" (Tamplin et al., 2018, p.9). More recently, Baker et al. (2019), describe a novel home-based music intervention where family carers are trained to interact with the family member with dementia daily through music or reading/story telling. Homeside is an ongoing international randomised controlled trial, further investigating music and other approaches that can meet needs at home for this population. Members of Together in Sound are involved in the Patient and Public Involvement (PPI) group, in designing and implementing the study, as well as advising on its move to online delivery, in response to COVID-19.

Community-based music therapy groups for people with Alzheimer's disease and their caregivers within a partnership project between a University and community organisation are described by Rio (2018). The groups are described as including "singing, instrument playing, movement and creation of new musical arrangements and improvisations based on in-the-moment needs, feelings and concerns" (Rio, 2018, p.3). New Zealand-based music therapist, Allan (2018) offers another example of a community-based music therapy project designed to support people living with dementia and their family caregivers where singing, playing instruments and listening to music were the focus of the intervention. Melhuish et al. (2019) report on the benefits of individualised home-based music therapy for caregiving dyads and emphasise the unique value of working in the home which enabled music therapists to respond to individual and sometimes challenging situations. Ridder

et al. (2013), similarly to Hsu et al. (2015), recognised three areas (catching attention and creating a safe setting, regulating arousal to a point of self-regulation, and musical interactions leading to communication for psychosocial needs) as central to effective music therapy technique and practice using improvisation with people with dementia. Both studies emphasise that the music in music therapy can incorporate live improvised music, song, and structured directed instrumental work, to meet identified aims. These examples demonstrate the growing interest in documenting different approaches to working with people with dementia and their caregivers.

TOGETHER IN SOUND

Together in Sound, an innovative collaboration between the arts sector and the music therapy department at Anglia Ruskin University, offers group music therapy and some dyad sessions in ten-week blocks. It includes placement opportunities for MA Music Therapy trainees and community experience for performing artists involved with Saffron Hall who attend training with the therapists prior to involvement in the project. This training includes induction and information about working with people with dementia as well as experiential music making and guidance. This ensures a shared understanding of how music is used in the sessions and the roles of the therapists and musicians. There are usually between four to nine couples per group with a maximum group size of 18 participants plus two therapists. Group sessions, which are co-facilitated by a registered music therapist and MA music therapy trainees, usually take place weekly in a community venue in the town and the team typically delivers three groups on each project day. The venue has been chosen for its relaxed environment and the availability of a social space that is separate from the therapy space.

Together in Sound is open to people living with a diagnosis of dementia who attend with a companion who is typically a family member or close friend and occasionally a professional carer. Usually the same companion attends each week to provide continuity and to support the relationship. Some exceptions are made to this to support regular attendance for the person with dementia. In the third year of the project and in response to feedback, group membership was extended to companions who had previously accompanied a person with dementia who was no longer able to attend the sessions (because they had moved into care for example or had died). While this has changed the dynamics of the groups to some extent, it has been an important commitment to the community who are at the heart of the project. Sessions last for 90 minutes with the first 30 minutes being an opportunity for socialising over drinks and biscuits. Volunteers from Saffron Hall play an important role before and after sessions to assist with teas and coffees, greeting and saying goodbye to participants.

Music therapy sessions are usually framed by a greeting and goodbye activity or song and a physical and vocal warm-up is included. A range of therapist-directed and non-directed activities are used including song singing (both familiar and new songs), listening to music, improvisation (free, theme and imagery-based improvisations are offered) and conversation. Participants are invited to share something of themselves and their experiences during the ten weeks; this may involve bringing in objects, photographs, music, songs, or stories to share with the group. This process supports relationship-building and enables participants to use the group for support and self-expression. The sessions are co-facilitated and take place within a closed, confidential, and time-limited group setting

with an additional element of a 'sharing' event. These sharing events usually happen once in every ten-week block of sessions and provide an opportunity for participants to share some of their experience with family, friends, and other invited stakeholders. Bringing in the wider community and guest musicians positions dementia as a community concern. The approach to music therapy therefore has elements of community music therapy in that it is a culturally and socially engaged practice where music is situated within the local context (Stige & Aarø, 2012). The sharing events are viewed as having a bridging function from the closed confidential therapy space to the wider community, thus creating a circle of support for those living with dementia. Participation in this context involves a commitment and willingness to "listen to all voices involved" (Stige & Aarø, 2012, p.148), to fostering inclusion, and building what Stige and Aarø refer to as "cultures of connectedness" (Stige & Aarø, 2012, p.149). Issues of power within the concept of participation evoke useful debate (Gregory, 2000; Stige, 2006) and the project team strives to create opportunities for discussion and reflection on the nature of participation with those concerned.

The overarching project aims are detailed below, however, each group process is distinct and evolves through the client-centred approach taken by the music therapist and trainees on placement. The following aims were generated collaboratively through conversation with participants and the project team:

- To support communication, healthy relationships, and quality of life through a collaborative group process.
- To provide opportunities for people with dementia and their companions to engage in music making.
- To provide opportunities for socialisation, forming support networks and relationships outside of the home environment with a view to reducing isolation.
- To share music with friends and family through 'public' sharing events.
- To provide 'up-close' opportunities to interact and listen to professional musicians.
- To support participants to 'live differently' through encouraging the use of music and music-based strategies at home.

Participation with carers and family aims to instil confidence, increase resilience, help social communication and awareness, and support the search for purpose and meaning. With this in mind, the project's approach is congruent with a biopsychosocial-spiritual perspective of dementia which helps us to consider health and wellbeing from a multi-faceted view of relationships that include physical, internal, external and existential concerns (Scott, 2016; Spector & Orrell, 2010; Sulmasy, 2002; Swinton, 2012). Furthermore, for the first time, in 2019, the National Institute for Health and Care Excellence (NICE, 2019) included music therapy in guidelines for people living with dementia. The different dimensions of this project are in line with these guidelines which advise that "activities such as exercise, aromatherapy, art, gardening, baking, reminiscence therapy, music therapy, mindfulness and animal assisted therapy" (NICE, 2019) are included in care to help promote wellbeing.

Impact of Together in Sound for participants

Together in Sound has provided a valuable opportunity to undertake research with participants in a natural setting utilising data such as video and audio recordings of music therapy sessions and clinical

notes. Evaluating the project has involved qualitative and quantitative methods of data collection including written feedback, focus group interviews and pre and post session questionnaires. As mentioned earlier, the first author is currently working towards completion of doctoral research using a narrative inquiry approach to explore the impact of the groups for participants.

Evaluation results have been positive over the past three years with the majority of participants and companions stating that they liked being able to meet new people, sing and share experiences with others, play instruments together and participate in the sharing event. Participants described Together in Sound as the "highlight of the week", "calming, encouraging", "fulfilling and relaxing." In both written evaluations and focus group meetings, participants have commented on the sense of unity in the groups: "Divisions vanished, and we were all one", "Dementia doesn't come into these sessions. We are just friends." Another theme that emerged in the evaluations was that the groups were as important for the companion as they were for the person with dementia: "I assisted [the participant] to enjoy herself and benefit from the music therapy – and I think I benefitted from the time out and being in the moment just as much as she did!" Pre and post session quantitative data demonstrates that sessions have a positive effect on participants' self-assessment of their sense of wellbeing, social connection with others and energy levels.

Collaboration and partnership are central to the project and feedback has enabled growth and development, such as extending the group membership to include solo companions as described earlier. Other changes implemented in response to feedback include the use of lyric sheets; objects, photographs, and themes to stimulate and engage; and for some groups, more structured activities to support engagement with improvisation.

IMPACT OF COVID-19 PANDEMIC ON TOGETHER IN SOUND

The impact of the COVID-19 pandemic and subsequent lockdown and isolation measures to protect public health has been significant for participants of Together in Sound. Already isolated by the impact of dementia, the lockdown has confined many participants to their homes. This section of the report will begin by presenting some relevant literature before turning to the team's response to the lockdown, the practicalities and considerations of offering sessions online, and reflections on the impact for participants and therapists.

Published research about the impact of COVID-19 upon people living with dementia, and how music therapy contributes, is sparse at the time of writing. In general terms, Galea et al. (2020) emphasise that in the wake of a global pandemic there is sometimes more focus upon immediate physical needs and the impact of the medical disease itself, than upon social and mental health needs. Unsurprisingly they highlight global early indications of a rise in poverty, mental health problems and social isolation, which supports adapting music therapy interventions to address these needs. Gaddy et al. (2020) discuss an early survey of music therapists' employment styles during the pandemic in the United States. They suggest results indicate that music therapists adapted to service delivery changes, continuing to provide services to clients, despite the many difficulties faced in the pandemic. Simonetti et al. (2020), in a medical facing study, conclude that the neuropsychiatric symptoms for people living with dementia appear to arise not only from the disease itself but from social restrictions in place as a consequence of the pandemic. Their findings so far indicate that the implementation of

caregiver support and skills of nursing and care staff are required to help restore social interaction. Relevant to our study, they cite the importance of adjusting technology in response to the pandemic. Further, Killen et al. (2020), in a study specifically examining the challenges of COVID-19 for people with dementia with Lewy bodies and their family caregivers, highlight the physical, cognitive and neuropsychiatric challenges associated, which may make this group particularly vulnerable to COVID-19. In addition, they advocate a multidisciplinary approach to support family caregivers, and recognise there may be adverse effects occurring from social isolation, also possible reductions in routine treatments and support, leading to a negative impact upon carers.

Three music therapy groups were meeting weekly at the beginning of 2020 and six sessions out of a ten-session block had been completed when the lockdown began. The Together in Sound team had already begun considering how to continue offering sessions in anticipation of the need to end in-person meetings. One of the frustrating aspects at this time (early March 2020) was not being able to plan while awaiting guidance from the UK government. The groups were in the middle of a therapeutic process and the lockdown would mean a sudden and unplanned ending. This, coupled with the knowledge that opportunities for connection and engagement outside the home were going to be seriously limited over the coming months and the feedback already gathered about the impact of the sessions for participants, created an imperative to continue.

While it was clear that using an online platform to deliver group music therapy sessions would be a very different experience for participants, it felt important to try in order to offer some continuity. On reflection, the desire to maintain a connection with and for participants was the main motivator. The final four weeks of sessions were offered to the three groups online and a further block of six sessions was offered during June-July. The reality of delivering sessions online and the impact of this is explored in more detail below.

Moving delivery online

Addressing the aims

When reflecting on the move to online delivery, it is worth returning to look at the aims for Together in Sound as outlined earlier in this report. The groups had already been working together for some time and some participants had been involved since the project began in 2017. Therefore, a significant investment in relationships and a strong sense of belonging already existed and had been expressed in the project evaluations and focus group meetings. This provided a strong foundation for moving online. In relation to the aims, online sessions could continue to support communication, healthy relationships, and quality of life through a collaborative group process. Opportunities for music making could be offered but would be limited by the musical resources participants had in their own homes. In terms of providing opportunities for socialisation and support networks, this felt vital and was a significant catalyst to continuing online. With the lockdown, came a complete loss of routine and structure for participants. Continuing to meet on a Friday would at least offer something stable amongst the sudden change everyone was facing. The sessions continued to provide opportunities to listen to professional musicians and it has been possible to host online sharing events. The final aim,

which concerns encouraging the use of music and music-based strategies at home, could also be addressed.

Practicalities of online delivery

Live sessions

Technical and pastoral support from Saffron Hall was essential to enable many participants to access the online sessions. Among other things, this involved the creation of a simple but detailed 'How to access Zoom' document for participants, practice sessions to access Zoom, telephoning participants prior to and during sessions to provide technical guidance and support, and following up with participants after sessions. Replicating the format of the in-person sessions as much as possible provided familiarity and consistency. To achieve this, sessions began with an informal time for chatting and sharing a cup of tea. This allowed time to resolve any technical issues and enabled people to arrive at the session when they were ready. A member of the Saffron Hall team stayed online during this tea-time which also replicated, to some degree, the presence of the volunteers who would have been at the in-person sessions. When ready to start the music therapy session, the Saffron Hall team member turned off their video and microphone but stayed online in case of technical issues.

Sessions continued to be co-facilitated by two therapists which made it easier to manage practical issues such as sharing lyrics on screen and song-writing. A typical session included the following:

- Hello song with guitar – participants' microphones are muted, and they are invited to sing with the therapist.
- Warm-ups – physical and vocal warm-ups, often involving simple stretches, breathing and playful vocal activities.
- Action song or call and response song - participants' microphones are muted and they are invited to participate vocally and physically.
- Pass the sound – this is an activity that was used frequently in in-person sessions and has transferred effectively to online sessions. Participants sometimes generate a theme to support the vocal sound they make such as animal or bird sounds, and sometimes engage with free vocalisations.
- Opportunity to listen to music provided by one of the therapists or a guest musician followed by time for reflection.
- Song singing – familiar and new songs with lyrics available on the screen and sent to participants beforehand.
- Song-writing using predictable structures such as 12-bar blues or a simple harmonic framework has worked effectively online with participants offering ideas for both lyric and musical content.
- Improvisation or playing together – (discussed further below).
- Time for reflection – this is sometimes an open space or linked to a particular musical interaction, song, or piece for listening.
- A familiar song to close the session.

Practical considerations that were learned early on include the importance of looking at the camera rather than at the screen which can help participants experience a sense of connectedness and using big gestures and simple verbal communications to support actions or instructions. Adjusting the audio settings on Zoom has assisted in improving the experience for participants. Another practical consideration that came from participants was the idea of 'curating the frame': participants began to bring objects, such as a vase of flowers, pictures, soft toys, or a colourful backdrop into the online frame as shown in Figure 1. This provided the opportunity for different interactions, to personalise the experience and offer something new to each other.

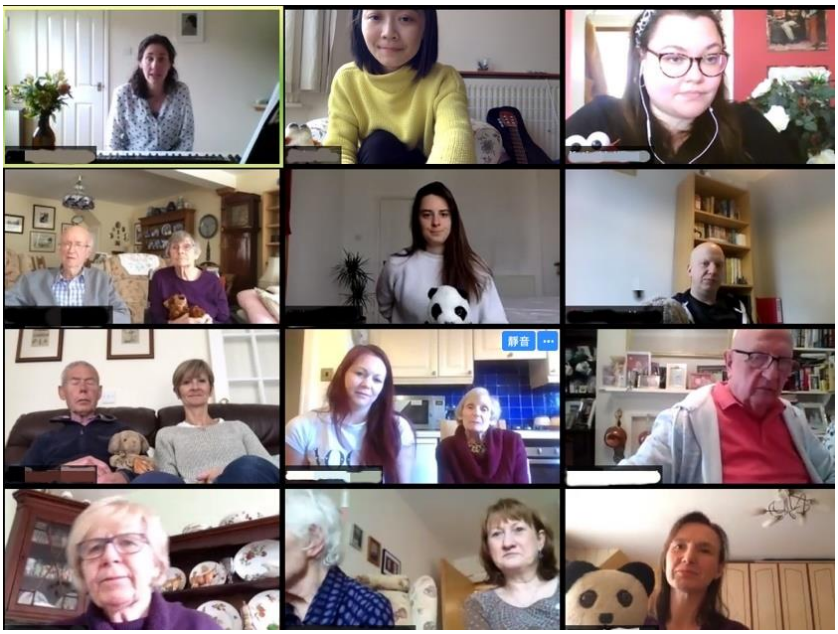

Figure 1: Curating the frame

Recorded content

Each of the live online sessions was recorded and made available for one week following the session on a password protected page for participants. This has been important for those who were unable to join the sessions live for whatever reason. Encouraging feedback from companions has been received reporting that they have used the recordings at other times during the week to provide stimulation and engagement for the person with dementia. Furthermore, in the weeks where there has been a break from online sessions, recorded content has been provided for participants to access. This has consisted of short videos recorded by Claire including songs, warm-ups, relaxation activities and musical content as well as recordings from guest musicians. The benefits of this resource bank are discussed further below.

Challenges and benefits of online delivery

Music making

With online delivery, the opportunities for musically rich group improvisations are limited as the technology does not allow groups to play or sing together synchronously. Thinking carefully about

the aims of specific musical invitations is helpful. For example, is the focus on the aesthetics of the experience, or is it more to do with social interaction and communication? This helps to make informed choices about whether participants are asked to mute their microphones to offer an experience of singing with the therapist. Or whether the group takes turns to sing individually and unaccompanied, which can emphasise the collaborative nature of creating and making music together.

For in-person sessions, a wide variety of engaging instruments was available. Meeting online has required creativity in relation to making music from home-made and found objects, and has provided opportunities for participants to demonstrate their resourcefulness. Improvisation might take place within the context of a song; for example, a recent song that was used included a volcanic eruption for which participants created sound effects. Alternatively, improvisation might be within the context of passing the sound around the group or creating a theme and variations. Participants have engaged with this experience and report that creating loud sounds from household objects such as saucepan lids has been cathartic or more meditative improvisations using gentle sounds from glassware are relaxing. Interestingly, the use of household items to make rhythmic sounds is included in the music intervention described by Baker at al. (2019) for the Homeside study which has been adapted for online delivery since the pandemic. Although changes have had to be made, the principles of using music to support communication, relationships and quality of life remain central. In relation to international trends in music therapy approaches in this field, Gold et al. (2019) report that core principles of the MIDDEL trial include the use of singing and musical instruments, which facilitate relationship between the music therapist and person living with dementia, whereas Baker et al. (2019) emphasise similar ingredients as necessary for the Homeside study, but focus upon how music facilitates the relationship between the person living with dementia and their home-based family caregiver. Both studies also highlight a core principle of affect regulation through active reciprocal music making, and the importance of focusing upon personal strengths, cultural background and social history.

Engaging online

For some participants living with dementia, there has been a high degree of engagement with the screen, while for others, it has been much harder to engage. There have been some couples where the person with dementia has chosen not to sit in front of the screen but might stay in the same room. Acknowledging the participant's presence during the session and imagining their experience of what they might be hearing in order to include them has been valuable. Using each other's names is important to help engagement and can provide orientation for the person with dementia to the screen.

In the first week, more than half of the usual participants joined the online sessions. This number increased over subsequent weeks. However, some participants did not join the online sessions at all, and it has not always been possible to gather feedback as to the reasons why. For some, it may be that they do not have the capacity to learn the new technology required to access the sessions or may not have the necessary equipment. Offering technical support, including individual opportunities to trial the online technology, has resulted in some participants joining the sessions. For other participants, the emotional impact of not being able to continue to meet in-person informed their decision to not join the online sessions. When this has been the case, the project team has tried to maintain contact with the participant, and invited them to stay connected through watching the

recordings of the live sessions. There were also several couples where the person with dementia moved into residential care during the lockdown. In these cases, the companion/s continued to attend the sessions and spoke of the importance of the group as support at this time of change in their lives.

One of the unexpected benefits of online delivery has been the capacity to reach participants who otherwise would not be able to attend sessions in the community. This included a participant who was bed-bound and nearing the end of life. Other group members expressed delight to see this participant join the sessions and there was opportunity to sing significant songs together. Melhuish et al. (2019) discuss the prominence of issues of loss and bereavement in their home-based work. For our project, online delivery brought the group into each other's homes. While this could be potentially intrusive, the relationships and trust previously established appear to have increased the group's capacity to support each other.

Non-verbal communication

For online delivery to work effectively, the therapists have found that communication has had to be more explicit. When working in the same physical environment, body language, gesture and eye contact can be used in ways that aim to engage and support interaction with participants. Online, these same resources are not available, and it is therefore helpful if the therapists' actions and invitations are more obvious. For example, turn-taking cannot be communicated through eye contact, but needs to be stated clearly using a person's name. Physical modelling cannot be directed so easily at an individual participant and needs to be moderated for the group as a whole. Giving clear, concise instructions and taking time to clarify or ask a participant to repeat something are simple, but important strategies for online delivery.

At times, the online sessions are easily dominated by verbal expressions instead of body or facial expressions, which means that it is more difficult to 'hear' from people with dementia who are less verbal. Checking in with movements or facial expressions from the small boxes on-screen is essential and easier with two therapists. Moreover, due to the limitation of the technology, it is difficult to hear more than one person talking at the same time. This presented a new difficulty which was sometimes resolved by 'muting' certain participants if they were talking over somebody or had background noise such as dogs barking or the telephone ringing that interrupted the conversation. For the therapists, however, it has felt uncomfortable to control the situation in this way, especially when the aim is for participants to be relaxed and talk as much as they want.

Follow up

A social tea-time is facilitated at the beginning of sessions and is an opportunity for participants to chat with each other. However, the opportunity for casual conversations or individual follow-up at the end of sessions is limited. It has therefore been important to be sensitive to any concerns about a participant's wellbeing and follow up individually with a telephone call or email communication after the session. For one participant, this included an opportunity for the therapist to sing a song over the telephone and for others, it has involved a supportive conversation and signposting to other support services as appropriate. Follow-up is done by either the therapist or Saffron Hall staff depending on the need.

The following section of the report presents reflections from the project team relating to their specific roles and are written in the first person.

Reflections from therapists (Claire Molyneux and Yu-Tzu Lin)

Working as co-therapists

As stated earlier, sessions are co-facilitated by Claire (registered music therapist) and trainees from the MA Music Therapy at ARU, with Yu-Tzu (Chloe) Lin co-facilitating during this period of online delivery. When delivering in-person, we had established a routine of setting up the room together and taking time to review our plan for the session; this time also allowed space to settle and focus our minds. In the sessions themselves, we were familiar with each other's musical and verbal repertoires and could easily engage in eye contact or gesture to support one another. These cues and the physical cooperation of preparing together were unavailable to us during online delivery as we were working from our own homes. One helpful strategy has been to meet online to plan at least an hour before the first session. This provided time to talk through the session plan, reflect on the previous session, anticipate potential needs, agree on roles (who is leading or supporting), play through or try out any musical material and plan for technical considerations such as screen sharing. Deliberately holding in mind our roles as co-therapists has been important. For in-person sessions, we were able to work as a dyad, providing a mirror for relating to one another musically and interpersonally through our physical presence. With online delivery, it is harder to present as co-therapists since the screen divides every pair of participants or individual into little boxes. Meeting prior to sessions and having co-supervision provided a space for us to connect as co-therapists, check in with each other, reflect on and explore our practice – endeavours which supported the coordinated delivery of therapy.

Continuing delivery online felt vital at this difficult time and it has been encouraging and heart-warming to see so many of our participants engage with what we have offered. One particularly emotional moment was seeing a couple connect online where the participant with dementia was bed-bound and had not been able to attend the sessions in the community for some months. In the new online format, it was possible to bring the music therapy sessions to this person's bedside. At the same time however, we were both acutely aware of those who were unable to join us for reasons described earlier. These experiences have connected us with feelings of being helpless and powerless; feelings that hold some resonance with the wider experience of the global pandemic. Supervision and space for reflection have been essential to ensure we can continue to offer a space where participants feel safe and confident to express their feelings and emotions. Staying connected with the ways that we might feel disempowered by the online delivery because the full extent of our communicative resource is unavailable may enhance our empathy and capacity to connect with the experiences of participants.

Using our imagination

Using our imagination is something with which we are familiar as therapists. By this, we do not necessarily mean imagination to create a variety of different musical experiences, rather the process of imagining the other person's experience. When working online, this has been critical. We have had to imagine what it might be like to experience the session on the other side of the screen. How do

participants experience the therapist's presence? And how can we use our online presence to convey intention and feeling? Full discussion of these questions is beyond the scope of this report. However, being open to each other's feedback as co-therapists and inviting feedback from participants has helped to bring a variety of perspectives for reflection and learning. For Yu-Tzu, as an international student with English as her second language, she reflected that 'there were times that I lost the words or couldn't follow the content from people on the screen. Therefore, I needed to pay more attention to the facial expressions from others and try to guess the meaning behind the communication' which may also resonate with the experience of some of our participants.

A lifeline

One of the main questions of our research concerns the impact of music therapy upon the wider community and lives of people living with dementia and their families. This will be explored in depth in later publications, but one way the participants have been keen to demonstrate impact has been through the public sharing events, interviews and participation with the media including newspapers and the BBC. Our approach to moving online was captured by the BBC early on in the lockdown and the resulting piece was broadcast first on local news, then on the BBC World news website and on the National News at One (BBC News, 2020). Participants welcomed this media coverage and saw it as an opportunity to contribute to dementia awareness which was particularly important during the COVID-19 lockdown period.

In the interview, one of the participants described the sessions as a 'lifeline'. The online Oxford dictionary defines 'lifeline' as follows (Lexico, 2020):

> A thing on which someone or something depends or which provides a means of escape from a difficult situation. A rope or line used for life-saving, typically one thrown to rescue someone in difficulties in water or one used by sailors to secure themselves to a boat.

For us as therapists, it felt very powerful for the groups to be described as a 'lifeline', something that could reach across a distance or span a chasm. The connection of lifelines with sea voyages also resonated with an earlier song that one of the groups had written about living with dementia that included images of dementia as a rough sea. While the sessions themselves could not change the physical reality of lockdown, they provided connection, community, shared understanding, and a sense of hope.

Reflections from Saffron Hall (Thomas Hardy and Katie McKinnon)

Together in Sound – a community

Over three years, Together in Sound has evolved to become a community which extends far beyond the group of participants living with dementia and their companions. This community encompasses a team of Saffron Hall volunteers who support each session, Claire and the ARU music therapy trainees, alumni who have had the opportunity to work on the project as a student placement, the former participants who are no longer able to attend – and their carers who in many instances remain part of

the groups, musicians from across the classical, folk and jazz worlds who participated in projects, and numerous friends, family members, supporters and others who have experienced, witnessed or been impacted by the project. Each session is a physical meeting of elements of this community, and termly sharing events give an opportunity for the wider community to come together to share music, food, and conversation. With the move to online delivery, as well as considering the participants, we were mindful of the impact on these other elements which are part of what makes Together in Sound special.

Bringing musicians from Saffron Hall's family of artists into Together in Sound has always been an important part of the project's philosophy. The setting provides musicians with valuable experience of working in the music therapy and dementia contexts, with robust support from Claire and the ARU team. In a world where musicians commonly have a portfolio career, moving between performing, teaching, composing and participatory work, they bring an important dynamic to the sessions, and for early career musicians, Together in Sound can offer a valuable training experience. In Spring 2020 we were working with three young musicians from our resident orchestra the London Philharmonic Orchestra's Future First programme. As well as a training event, they had attended one session and were preparing to participate in the sharing event. Their subsequent involvement in some of the online sessions brought an extra dimension of live performance. In a world where live music making in front of an audience was not possible, it was a powerful reminder of music's power to bridge divides. Figure 2 shows participants listening attentively and singing along with the LPO musician who was playing *Moon River* on her trumpet (top).

Figure 2: Listening to *Moon River*

Online resources

It was a beautiful surprise to receive video recordings from two musicians who are members of our resident ensemble Britten Sinfonia. The musicians, who had participated in Together in Sound over a year earlier, had heard about the project moving online and wanted to connect with the participants at this difficult time. The music they shared was really appreciated by participants, many of whom

remembered their involvement in the groups. The fact that Together in Sound was on their minds at this time truly reflects the ideas expressed above about the project's wider community being an important element. This reconnection may not have happened without the unprecedented circumstances and has prompted thoughts about ways to maintain connections with others whose direct involvement in the project may not be long-term. In the immediate term we have taken the opportunity to reconnect with other musicians who had participated earlier in the project and have commissioned further videos to share with the participants.

The creation of an online resource bank (described earlier) may have been born in a crisis but might not have happened in more normal times. It has been well used and appreciated by many participants and, we anticipate, will continue to be a part of the project. We are always aware that we are only with participants for a short part of their week, and an accessible online offer could provide support and comfort between sessions.

CONCLUDING THOUGHTS

This report has outlined the Together in Sound project's experience of moving sessions online in response to the COVID-19 pandemic. While all involved are looking forward to returning to in-person meetings in the future, this period of online delivery has opened helpful questions about how to develop what is offered. Accessibility for participants beyond the time they are able to physically attend sessions in the community, an online bank of recorded resources, increased connection with guest musicians, and the possibility of live-streaming sharing events to increase access to those unable to join in-person, are all ideas for consideration. Participant voice is an essential part of Together in Sound and feedback about this period of online sessions has been collected from participants in an online focus group. The team plan to publish these findings in the future to include more participants' voices.

Although not possible to have the usual in-person sharing events, an online sharing event was held in July 2020. Bringing together participants, volunteers, friends and families, guest musicians and others is the truest expression of Together in Sound – and indeed Saffron Hall – as a community. The online sharing, with 'audience' in attendance, was an opportunity to celebrate the strength, resilience and positivity shown by the participants, music therapists and musicians at a difficult time. This community has faced incredible challenges in the last few months, but have remained Together in Sound throughout, and the world is a richer place for it.

REFERENCES

Ahonen-Eerikäinen, H., Rippin, K., Sibille, N., Koch, R., & Dalby, D. M. (2007). "Not bad for an old 85-year-old!" – The qualitative analysis of the role of music, therapeutic benefits and group therapeutic factors of the St Joseph's Alzheimer's adult day program music therapy group. *Canadian Journal of Music Therapy, 13*(2), 37-62.

Allan, M., (2018). Community music therapy to support the relationship between family caregivers and people living with dementia: A pilot project. *New Zealand Journal of Music Therapy, 16*, 31-54.

Baker, F. A., Grocke, D., & Pachana, N. A., (2012). Connecting through music: A study of a spousal caregiver-directed music intervention designed to prolong fulfilling relationships in couples where one person has dementia. *Australian Journal of Music Therapy, 23*, 4-19.

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

BBC News. (2020, April 22). *Coronavirus: Online music therapy group a 'lifeline' in pandemic.* https://www.bbc.co.uk/news/av/uk-england-essex-52375524/coronavirus-online-music-therapy-group-a-lifeline-in-pandemic

Bowell. S., & Bamford, S. M. (2018). *'What would life be – without a song or a dance, what are we?' A report from the commission on dementia and music.* International Longevity Centre. http://www.ilcuk.org.uk/index.php/publications/publication_details/what_would_life_be_without_a_song_or_a_dance_what_are_we

Brotons, M., & Marti, P. (2003). Music therapy with Alzheimer's patients and their family caregivers: a pilot project. *Journal of Music Therapy 40*, 138-150.

Clair, A., & Ebberts, A. (1997). The effects of music therapy on interactions between family caregivers and their care receivers with late stage dementia. *Journal of Music Therapy, 34*, 148-164.

Clark, I. N., Tamplin, J. D., & Baker, F. A. (2018). Community-dwelling people living with dementia and their family caregivers experience enhanced relationships and feelings of well-being following therapeutic group singing: A qualitative thematic analysis. *Frontiers in Psychology, 9*: 1332. https://doi.org/10.3389/fpsyg.2018.01332

Dowlen, R., (2018). *The 'in the moment' musical experiences of people with dementia: A multiple-case study approach.* [Doctoral dissertation, The University of Manchester] The University of Manchester Research Explorer. https://www.research.manchester.ac.uk/portal/en/theses/the-in-the-moment-musical-experiences-of-people-with-dementia-a-multiplecase-study-approach(48599400-3e3d-4871-a0e3-94d6b3692a5d).html

Gaddy, S., Gallardo, R., McCluskey, S., Moore, L., Peuser, A., Rotert, R., Stypulkoski, C., & LaGasse, A. B. (2020). COVID-19 and music therapists' employment, service delivery, perceived stress, and hope: A descriptive study. *Music Therapy Perspectives, 38*(2), 157-166.

Galea, S., Merchant, R. M., & Lurie, N. (2020). The mental health consequences of COVID-19 and physical distancing: The need for prevention and early intervention. *JAMA Internal Medicine, 180*(6), 817-818.

Gold, C., Eickholt, J., Assmus, J., Stige, B., Wake, J. D., Baker, F. A., Tamplin, J., Clark, I., Lee, C., Jacobson, S., Ridder, H. M. O., Wosch, T., Ceccato, E., Raglio, A., Ruggeri, M., Vink, A., Zuidema, S., & Odell-Miller, H. (2019). Music Interventions for Dementia and Depression in ELderly care (MIDDEL): protocol and statistical analysis plan for a multinational cluster-randomised trial. *BMJ Open, 9*(3), e023436.

Gregory, A. (2000). Problematizing participation: A critical review of approaches to participation in evaluation theory. *Evaluation, 6*(2), 179-199.

Hsu, M. H., Flowerdew, R., Parker, M., Fachner, J., & Odell-Miller, H. (2015). Individual music therapy for managing neuropsychiatric symptoms for people with dementia and their carers: a cluster randomised controlled feasibility study. *BMC Geriatrics*, *15*(84). https://doi.org/10.1186/s12877-015-0082-4

Killen, A., Olsen, K., McKeith, I. G., Thomas, A. J., O'Brien, J. T., Donaghy, P., & Taylor, J. P. (2020). The challenges of COVID-19 for people with dementia with Lewy bodies and family caregivers. *International Journal of Geriatric Psychiatry.*

Lexico, (2020). https://www.lexico.com/definition/lifeline

Melhuish, R., Grady, M., & Holland, A. (2019). Mindsong, music therapy and dementia care: Collaborative working to support people with dementia and family carers at home. *British Journal of Music Therapy, 33*(1), 16-26.

National Institute for Health and Care Excellence (NICE). (2019). *Dementia: Quality standard* Published: 28 June 2019. https://www.nice.org.uk/guidance/qs184

Pugh, R. (2016). Could music projects cut the cost of dementia care? *The Guardian,* [online] 29 February. https://www.theguardian.com/social-care-network/2016/feb/29/music-projects-cut-cost-dementia-care

Raglio, A., Bellelli, G., Traficante, D., Gianotti, M., Ubezio, M., Villani, D., & Trabucchi, M. (2008). Efficacy of music therapy in the treatment of behavioral and psychiatric symptoms of dementia. *Alzheimer Disease and Associated Disorders*, *22*(2), 158–162. doi: 10.1097/WAD.0b013e3181630b6f

Raglio, A., Belleli, G., Traficante, D., Gianotti, M., Ubezio, M. C., Gentile, S., Villani, D., & Trabucchi, M. (2010). Efficacy of music therapy treatment based on cycles of sessions: A randomised controlled trial. *Aging and Mental Health, 14*(8), 900–904. doi: 10.1080/13607861003713158

Rausch, A., Caljouw, M. A. A., & van der Ploeg, E. S. (2017). Keeping the person with dementia and the informal caregiver together: A systematic review of psychosocial interventions. *International Psychogeriatrics*, *29*(4), 583-593.

Ridder, H. M., (2011). Effects of music therapy in dementia: Turning practice-based research into an RCT. *Music Therapy Today*, *9*(1), 36-37.

Ridder, H. M., Wigram, T., & Ottesen, A. M. (2009). A pilot study on the effects of music therapy on frontotemporal dementia – developing a research protocol. *Nordic Journal of Music Therapy, 18*(2), 103-132.

Ridder, H.M., Stige, B., Qvale, L., & Gold, C. (2013). Individual music therapy for agitation in dementia: An exploratory randomized controlled trial. *Aging & Mental Health*, *17*(6), 667–678.

Rio, R. (2018). A community-based music therapy support group for people with Alzheimer's Disease and their caregivers: A sustainable partnership model. *Frontiers in Medicine, 5:*293. doi: 10.3389/fmed.2018.00293

Scott, H. (2016). The importance of spirituality for people living with dementia. *Nursing Standard, 30*(25), 41–50. https://doi.org/10.7748/ns.30.25.41.s47

Simonetti, A., Pais, C., Jones, M., Cipriani, M. C., Janiri, D., Monti, L., Landi, F., Bernabei, R., Liperoti, R., & Sani, G. (2020). Neuropsychiatric symptoms in elderly with dementia during COVID-19 pandemic: Definition, treatment, and future directions. *Frontiers in Psychiatry, 11*.

Spector, A., & Orrell, M. (2010). Using a biopsychosocial model of dementia as a tool to guide clinical practice. *International Psychogeriatrics 22*, 957-965.

Stige, B. (2006). On a notion of participation in music therapy. *Nordic Journal of Music Therapy, 15*(2), 121-138. DOI: 10.1080/08098130609478159

Stige, B., & Aarø, L. E. (2012). *Invitation to community music therapy* (1st ed). Routledge.

Swinton, J. (2012). *Dementia: living in the memories of God.* SCM Press.

Sulmasy, D. P. (2002). A biopsychosocial-spiritual model for the care of patients at the end of life. *The Gerontologist, 42*(3), 24-33.
Svansdottir, H. B., & Snaedal, J. (2006). Music therapy in moderate and severe dementia of Alzheimer's type: A case-control study. *International Psychogeriatrics, 18*(4), 613-621.
Tamplin, J., Clark, I. N., Lee Y-E. C., & Baker, F. A. (2018). Remini-Sing: A feasibility study of therapeutic group singing to support relationship quality and wellbeing for community-dwelling people living with dementia and their family caregivers. *Frontiers in Medicine, 5*, 245 https://www.frontiersin.org/article/10.3389/fmed.2018.00245
van der Steen, J. T., Smaling, H. J.A., van der Wouden, J. C., Bruinsma, M. S., Scholten, R. J. P. M., & Vink, A. C. (2018). Music-based therapeutic interventions for people with dementia. *Cochrane Database of Systematic Reviews 7*. Art. No.: CD003477. DOI: 10.1002/14651858.CD003477.pub4
Vink, A. C., Zuidersma, M., Boersma, F., de Jonge, P., Zuidema, S. U., & Slaets, J. P. (2013). The effect of music therapy compared with general recreational activities in reducing agitation in people with dementia: a randomised controlled trial. *International Journal of Geriatric Psychiatry*, *28*(10), 1031–1038. https://doi.org/10.1002/gps.3924
Wittenberg, R., Hu, B., Barraza-Araiza, L., & Rehill, A., 2019. *Projections of older people with dementia and costs of dementia care in the United Kingdom, 2019-2040.* Care Policy and Evaluation Centre, London School of Economics and Political Science. Report funded by Alzheimer's Society. https://www.alzheimers.org.uk/sites/default/files/2019-11/cpec_report_november_2019.pdf

Ελληνική περίληψη | Greek abstract

Μαζί στον Ήχο [Together in Sound]: Ομάδες μουσικοθεραπείας για άτομα με άνοια και τους συνοδούς τους – διαδικτυακή μεταφορά των συνεδρίων ως ανταπόκριση στην πανδημία

Claire Molyneux, Thomas Hardy, Yu-Tzu (Chloe) Lin, Katie McKinnon & Helen Odell-Miller

ΠΕΡΙΛΗΨΗ

Το πρόγραμμα Μαζί στον Ήχο [Together in Sound] είναι μια συνεργασία ανάμεσα στο Ινστιτούτο του Cambridge για την Έρευνα στη Μουσικοθεραπεία του Anglia Ruskin University (ARU) και το Saffron Hall Trust, ένα καλλιτεχνικό φιλανθρωπικό οργανισμό που εδρεύει στα περίχωρα του Essex στην Αγγλία. Το πρόγραμμα ξεκίνησε το φθινόπωρο του 2017 προσφέροντας μουσικοθεραπεία σε άτομα με άνοια και τους συνοδούς τους, και περιλαμβάνει ένα πρακτικά προσανατολισμένο ερευνητικό μέρος. Αυτή η αναφορά, η οποία έχει συγγραφεί από κοινού, εστιάζει στον αντίκτυπο της πανδημίας του COVID-19 στο συγκεκριμένο πρόγραμμα και παρουσιάζει την εμπειρία της ομάδας αναφορικά με τη διαδικτυακή μεταφορά των συνεδριών μουσικοθεραπείας από τον Μάρτιο του 2020. Η διαδικτυακή συνέχιση του προγράμματος παρείχε μια αίσθηση συνοχής, υποστήριξης και συνεχιζόμενης διασύνδεσης με τους συμμετέχοντες, οι οποίοι, εξαιτίας της απαγόρευσης κυκλοφορίας στο Ηνωμένο Βασίλειο, παρέμειναν απομονωμένοι στις κατοικίες του. Μετά την περιγραφή του πλαισίου του προγράμματος, η αναφορά αυτή διερευνά τις προκλήσεις και τα οφέλη των διαδικτυακών συνεδριών μέσα από τον αναστοχασμό της ομάδας Μαζί στον Ήχο, συμπεριλαμβάνοντας πιθανές επιπτώσεις για το μέλλον.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

διαδικτυακή μουσικοθεραπεία, άτομα με άνοια, ζευγάρια φροντιστών, πανδημία του COVID-19

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REPORT

Special Feature | Reports on online music therapy

The North London Music Therapy Phone Support Service for NHS staff during the COVID-19 pandemic: A report about the service and its relevance for the music therapy profession

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ABSTRACT

In March 2020, reports showed National Health Service (NHS) staff in the United Kingdom experienced significant strain treating COVID-19 patients. Music therapists have skills to offer in the treatment of mental health; this report describes how North London Music Therapy (NLMT) designed and ran a new Phone Support Service providing acute telephone support, rather than therapy, for NHS staff, launching three weeks before the NHS' own support service. This report will outline the procedure for setting up the service and examine the motivations behind developing the service. NLMT received self-referrals from across the UK, with 50% of referrals accepting initial phone calls and 50% of these completing three phone support sessions. NLMT received 100% positive feedback from all participants, signposting effectively at the end of service. NLMT has been nominated for an Advancing Healthcare ESTEEM Award for the Phone Support Service, because of the speed in which it was set up and because of the service provided to key workers. The service is still available but, now the NHS has launched internal support services, NLMT's focus has now shifted to aftercare support for key workers and their organisations.

KEYWORDS

COVID-19,
mental health,
Psychological First Aid,
phone service,
music therapy

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INTRODUCTION

In the middle of March 2020, the UK became seriously affected by COVID-19. People were becoming ill, hospitals were becoming fuller, supermarket shelves were emptying. At this time, the UK Government directive was simply, 'Wash your hands,' which, while useful, felt too straightforward and did not seem to match the anxious mood of the general public.

Medical professionals continued as usual, with the added pressure of intensive care unit (ICU) beds filling up at a rapid capacity, even more than the expected spike of patients in the winter would usually allow. Newspapers reported National Health Service (NHS) staff feeling overwhelmed by their work. At this point, there was an overflow of patients, with operating theatres being transformed into intensive care units (Campbell et al., 2020). Staff were reporting symptoms of anxiety, overwhelm, emptiness, burnout and shock at the level of death and the illness and fragility of their patients.

In an attempt to mitigate some of the anxiety and pressure felt by local NHS staff and key workers, my organisation, North London Music Therapy (NLMT), set up a service to directly intervene and offer support. The Phone Support Service was intended as a form of Psychological First Aid (Everly, 2020) for staff experiencing acute trauma symptoms as a result of caring for inpatients with COVID-19, and the associated professional and personal anxieties, especially regarding coping with the psychological implications of the pandemic, lockdown and the seriousness of the situation.

In this report I describe the process of setting up the service, outline the main findings and discuss what we have learnt, including the main recommendations music therapists should consider. The Phone Support Service may also have merit for therapeutic professionals who do not use music; I would hope that the recommendations outlined would also be useful to those professionals.

BACKGROUND

NLMT specialises in working with people in the community with mental health concerns. In practice, this mostly means working with people with either a diagnosis of an anxiety disorder or who are experiencing symptoms of anxiety. These are often comorbid with other conditions such as depression, autism, eating disorders and so on, and are often the result of early trauma. Most of our work is with self-funding patients who are on open-ended contracts, therefore the majority of our work is long term, counter to the prevailing therapy model in the UK. At the moment NLMT is a small team, consisting of myself and one other music therapist who is also responsible for NLMT's social media.

NLMT were able to move all existing clients to remote versions of their sessions by 19th March 2020. We were in a more fortunate position than other music therapy organisations as all our clients are verbal, so they were able to give consent and to reflect with us as to the practicalities and the new considerations of remote working. We also had to design a process for this; some patients elected for audio only sessions, via WhatsApp, and some requested video sessions, via various platforms.

This early completion of transition to remote working meant we had time and opportunity to consider how else we might be able to offer services. I had also become acclimatised to writing procedural documents; not only had I been the main author for NLMT's Remote Services, I also led the writing of 'Guidance for Music Therapists during the COVID-19 outbreak' for the British Association for Music Therapy (Rizkallah, 2020).

SERVICE OUTLINE

NLMT staff expressed a similar desire to contribute skills to the NHS. I began to design an outline of what became the Phone Support Service while noticing that I had not found what I felt to be an adequate blueprint for setting up this kind of acute service. We did not know the demand for the service

and could not forecast its efficacy. We were affected by news reports of NHS staff under intense pressure and were motivated by a desire to help.

It felt like my only UK reference points were Childline (Childline, 2020) and the Samaritans (Samaritans 2020), both long-standing, well-respected phone support services in the UK, available at all times for people in terms of crisis and with a high level of trustworthiness in terms of respect for confidentiality. While I knew that NLMT would not have the resources to offer phone support on the same scale, I hoped that we would be able to take inspiration from these service providers and communicate a high level of trustworthiness to potential service users. Taking inspiration solely from two large, national service providers perhaps suggests that this project was entered into with some haste - but that suggestion would be correct. In March, I and what felt like everyone around me was experiencing significant anxiety; my way of attempting to mitigate that in my own mind was to sublimate my fears into working on something I felt could be positive.

I knew of a similar phone support service being set up for NHS practitioners on a much larger scale (Frontline 19, 2020) and felt that NLMT's part to play in this, while necessarily smaller, could be a useful experiment to model future work. Frontline 19 were going to offer a similar service, however at that point in time it had not yet launched and gave no indication as to when they would be able to; we were ready to launch immediately, albeit on a smaller scale, and felt that time was of the essence as key workers and NHS staff required emotional support as soon as possible, on the grounds of improved mental wellbeing. At that time, no one could have any idea of the trajectory of Governmental restrictions or indeed the national spread of COVID-19 - at this point in time lockdown had only just begun and the general mood of the population seemed to be turning to that of extreme fear, with a spike in reports of depression and anxiety symptoms the day after lockdown was announced (Armour, 2020, Bentall et al 2020).

My initial concern was that a Phone Support Service could be offered too early – research into trauma suggests that attempts at early treatment can re-traumatise some victims (Everly, 2020). My own experience working as a music therapist with the local community after the Grenfell disaster pointed to grief counselling models as being the most helpful in terms of offering support to residents (Kubler Ross 1969, Parkes, 2009, Worden, 1983).

However, I felt sure that our therapeutic skills could be offered in some form as acute support for key workers. I found some studies suggesting that early intervention may be able to mitigate PTSD symptoms in some staff (Glaspey et al., 2017); while the research here is drawn from a small pool, initial findings suggested a similar service could help. My colleague Jonathan Cousins-Booth alerted me to Psychological First Aid, a training his company had received (Everly, 2020) and suggested this could be a useful model to inform NLMT's Phone Support Service. NLMT staff undertook Psychological First Aid training, and this was used as the main model behind our service.

It therefore feels key to stress that the Phone Support Service was not an attempt to offer therapy. Attempting therapy was not an aim of the service and it would have been inappropriate. The Psychological First Aid training stressed the importance of a listening ear and offering validatory comments rather than challenging ones, so that service users might feel heard and understood, rather than offering in-depth therapy. From my own experience, the burden on loved ones can feel very great when trying to support someone experiencing trauma; the Phone Support Service was also an attempt to mitigate some of that burden.

In practice, this meant that when service users spoke to us on the phone during sessions – for example talking about a difficult situation at work and how it had made them feel – instead of wondering out loud how this might link to another experience or whether it could be mirrored in another relationship, perhaps from earlier in a service user's life, we paraphrased what was being said and reflected it back without expanding on it. This was because we felt that the people using our service would be best served by an approach that gave people permission to feel the shock and bewilderment that they reported feeling. Someone experiencing acute trauma feels in uncharted waters, away from thoughts and experiences they know. This experience can be completely disorientating and it can make people feel unreal and unsure of themselves and their existence. The most appropriate type of support in this case is one that reorientates, allows for confusing feelings, and does not further move someone away from where they feel they have become unmoored from.

Ethical questions and dilemmas

As part of setting up the service, the safety of both participants and staff was paramount. It was clear that all participants should expect confidentiality as part of the work. As the work was based within the UK, still currently a member of the European Union, the minimal personal details we collected (email addresses and a brief personal history) were stored in line with General Data Protection Regulations (GDPR). As we had no access to centralised telephone systems with work phone numbers, we had to use mobile phones to make the calls. No personal mobile numbers were given out, and all therapists hid their caller ID before making a call.

I was also concerned not to capitalise on a global disaster. Now was not the time to offer therapy in a conventional form, and I also felt strongly that the service should be free for all service users. We did not know at that point how much of a difference there would be between telephone sessions compared to a face-to-face service; we were learning alongside other therapists in the early stages of lockdown. We sought no funding for this project, instead we utilised volunteering time and energy in order to make it work. I chose this approach because I felt time was of the essence - if we were to offer an acute service we needed to reach people who needed help immediately, as seen in the UK press. Furthermore, I did not want to have to adhere to a fundraiser's necessary time constraints in order for work to be able to begin. I did, however, consider that funding would be a necessary component of longer-term work and so began researching funding options.

Structure of the phone support

I designed the referral procedure for the Phone Support Service through creating a procedural document, receiving external consultation on the final outline. The pathway ran as shown in Figure 1.

Three sessions were agreed on as a suitable amount of time for service users to make full use of acute support without the relationship transforming into a longer-term therapeutic one. Service users were offered music making as part of the work, including playlist building and receptive music therapy-style techniques – this also appeared as part of the advertising – but no service user took up this aspect of the offer. This is interesting to consider in more detail. All service users reported that it was most important for them to have a space to talk and 'offload.' As all were verbal (not always a

given for music therapists) and the subject matter needing to be offloaded was so distressing, perhaps the directness of using language was what felt important for service users. However, this runs counter to the idea that music therapy can be used as a form of self-expression when language is not able to illustrate what is needed to be expressed. Music therapists receive training in verbal intervention as well as musical; certainly, it did not disturb either myself or the other project therapist to be delivering verbal interventions as we are both of the view that this is within our skill set. Some musical discussion did occur with one patient, who talked about the types of music she prefers to listen to when feeling distressed; she was able to talk about music as a means to affect her mood. It could be suggested that the inclusion of musical input in our advertising, as well as the name of our organisation including the term 'Music Therapy', could have been a factor in participants choosing our Support Service, even if music was not ultimately used as part of the intervention. We would only know this for certain, though, if further participant evaluation was carried out.

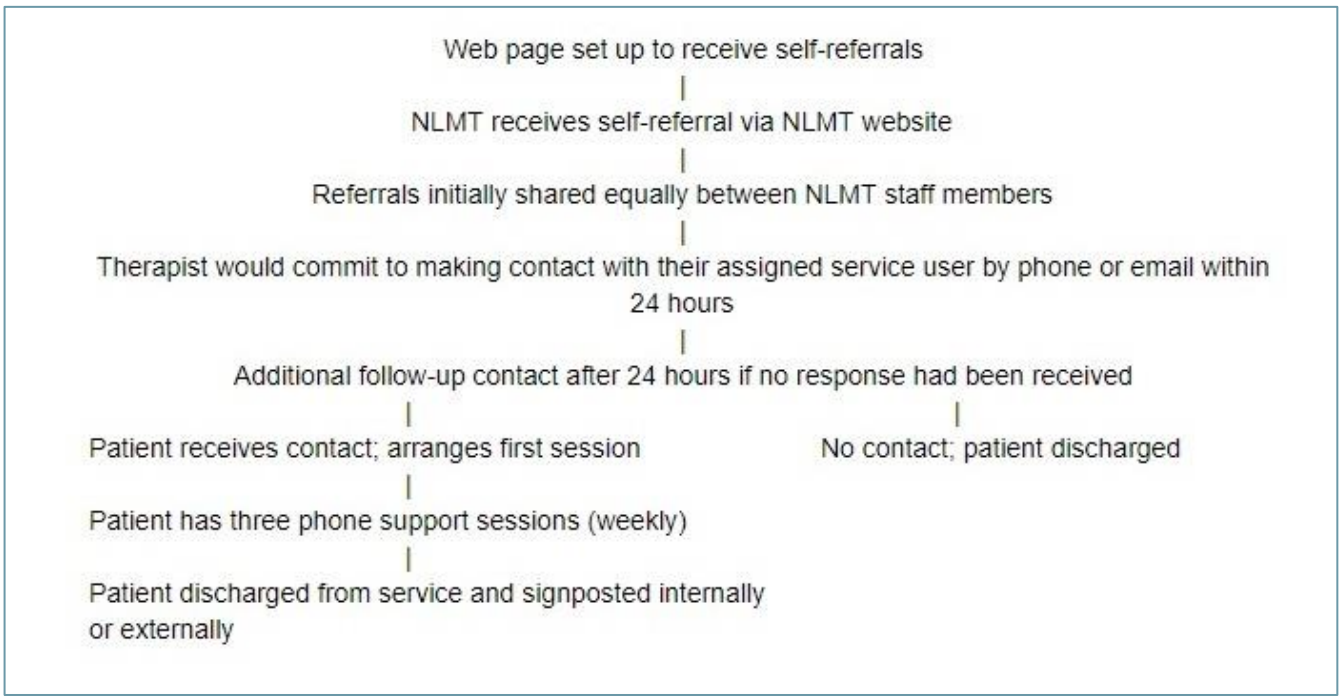

Figure 1: Outline of Phone Support Service procedure

While the service was advertised to all key workers, the referrals came from NHS staff. Many spoke about the distress of working with COVID-19 patients: the level of death especially in previously healthy patients; the claustrophobia and inconvenience of wearing personal protective equipment (PPE); the difficulties with being unable to give patients the usual level of care such as brushing hair or simply sitting with a patient for a while. As a result, staff taking calls reported feeling drained and exhausted, and that a great level of emotion needed to be 'held' (Winnicott, 1962) by each therapist in order for each service user to have enough space to offload.

Clinical supervision was provided by an external clinical neuropsychologist (with an additional therapeutic background) known to me, who provided her services in kind for the duration of the initial wave of the service. It felt important that the work was supervised by someone experienced in short-term working; the majority of NLMT work is with long-term service users, therefore I was aware that a

change in our usual thinking would be necessary beyond the differing needs of this client group. Peer supervision sessions were held, which again I felt were important to acknowledge what felt like the lack of blueprint for such a service, and to acknowledge that everyone taking phone calls as part of the service was trying to find their way through and that no-one had more experience than the other in offering this type of service.

Running the service

The Phone Support Service was launched on 3rd April 2020, before any other similar UK phone service directly related to COVID-19 was launched (as far as I am aware). Three weeks after our Phone Support Service launched, the NHS rolled out its own crisis response, and many potential NLMT referrals were redirected towards that service. We did not wish to go into competition with the NHS, especially as we primarily spoke to NHS staff, and consequently withdrew publicity at this point in time.

Therefore, our service ran at full capacity for a short period of three weeks, running entirely on word of mouth and organic advertising (i.e. advertising that was put out through NLMT social media and web channels and did not receive paid-for boosts in reach). Most referrals came to NLMT's Phone Support Service in the first 24 hours. We received enquiries from London, Manchester and the Midlands, with 50% of enquiries receiving initial calls, and 50% of those completing three phone sessions as part of the service. Two therapists handled all of the calls (myself and NLMT's other music therapist), averaging four calls a week when the service was running at full capacity. In total, 22 phone calls and emails were made to participants, including initial enquiry and evaluation calls. Each participant that took part in the service received three support phone calls, all of which took place in weekly intervals.

As we did not know whether and when the NHS or another large organisation would launch a similar service on a national scale with wider reach, we anticipated a spike in referrals, and recruited a number of therapists external to NLMT to take calls if needed. All completed Psychological First Aid training in preparation. In the end, no further therapists were used as once the NHS's service was launched, NLMT's referrals decreased significantly.

NLMT asked all participants in the Phone Support Service to complete a brief feedback form, asking for a service rating from 0-10 and a numerical score of how likely they were to recommend the service from 0-10 (in both cases 10 being the highest). We also requested testimonials from service users. Overall, 100% of survey respondents rated the service at 8 or higher. All participants opted for signposting outside of the organisation, with one service user stating that they would consider coming for further therapeutic treatment with NLMT at a future date. It is important to state that this service was not designed to gain new referrals for NLMT and was intended as a standalone service to provide acute support.

Therapist experience

Both I and my NLMT colleague Priya Vithani initially reported feeling exhausted and overwhelmed by the content of the calls, needing to allocate time for reflection and self-care immediately afterwards. We both found peer supervision essential as a means of reflecting and understanding the level of

emotion communicated during the calls; additionally, I receive psychoanalysis and found sessions invaluable during this time. We spoke in peer supervision about how the Psychological First Aid training encouraged strong listening skills, and that its renewed focus was helpful for us to think about during phone sessions.

Video feedback

A doctor based in Manchester, known to me but who encouraged referrals within her team for the service, sent a film clip to NLMT of her listening to music in her car on the drive home after a night shift, saying she had been inspired by the service's work to include music more widely in her day, and that she found it calming. She expressed a wish for the video to be shared and gave permission for NLMT to use it as advertising.

The video was launched on 20th April on YouTube (NLMT, 2020a) and across all NLMT social media platforms. It received over 16,000 views on Twitter in 24 hours (NLMT, 2020b) and was retweeted by several prominent UK politicians.

Aftercare

The Phone Support Service is still available, and we will return to advertising it if there is a second lockdown or a notable spike in COVID-19 related mental health cases reported widely. We note that the NHS internal support service and Frontline 19 services are also continuing. NLMT has been nominated for an Advancing Healthcare ESTEEM Award (Chamberlain Dunn, 2020) for the Phone Support Service, due to the speed in which it was set up and because of the service provided to the key worker community.

NLMT's ongoing focus is developing a new aftercare service for service users and the organisations they serve. This will be in group form and will contain musical and verbal components. It will be offered online or in-person, providing flexible opportunities for organisations to receive support.

CONCLUSIONS AND FURTHER APPLICATION OF THE WORK

This report will hopefully be useful to other music therapy practitioners and organisations within and beyond the UK who may consider setting up a similar new service or who are converting their existing services to an online format. By outlining the steps we took both in terms of setup and designing a process for how the service was run, I hope this information can prove valuable to others. While the option of musical intervention is specific to music therapists, other psychological or healthcare organisations working with those who have experienced trauma may consider themselves able to set up a similar Support Service. Psychological First Aid training is absolutely necessary in order to be able to carry out this work in the manner of NLMT's Phone Support Service.

The key learning from setting up this service was that our clarity of process enabled service users to trust that a small organisation such as NLMT could be trusted to carry out an important and confidential service. We set clear parameters and boundaries, we were transparent with our aims, and

we did not stray beyond what we had set out to achieve. I think this knowledge is transferable into the music therapy field more widely, as clarity of process when pitching for new work or setting up new services is key to not only coming across as an approachable, prudent organisation, but also clearly explaining what music therapy is, which is still of paramount importance in so many cases.

We can also see, from the video sent to NLMT by the doctor and feedback from a service user, that the service inspired medical staff involved with the Phone Support Service to use music more prominently in their everyday lives to produce positive emotional benefits.

I was also pleased that, even though a by-product of launching such a service was the raising of brand awareness, we did not tie in the Phone Support Service with a more general recruitment drive to therapy. I think in this case, as it was a response to the global pandemic, it would have hurt the brand to have attempted to overtly gain new referrals, as it would have muddled our offer. We were offering Psychological First Aid specifically because we did not consider therapy appropriate during a period of acute trauma, therefore to suggest we would also be able to imminently provide therapy in this case would not have worked.

REFERENCES

Armour, S. (2020). Depression and anxiety spiked after lockdown announcement, coronavirus mental health study shows. *University of Sheffield*. https://www.sheffield.ac.uk/news/nr/depression-anxiety-spiked-after-lockdown-announcement-coronavirus-mental-health-psychology-study-1.885549

Author unknown (2020). Childline. https://www.childline.org.uk/

Author unknown (2020). Frontline 19. https://www.frontline19.com/

Author unknown (2020). The Samaritans. https://www.samaritans.org/

Bentall, R. et al. (2020). Initial research findings on COVID-19 and mental health in the UK. *COVID-19 Psychological Research Consortium (C19PRC)*. https://drive.google.com/file/d/1A95KvikwK32ZAX387nGPNBCnoFktdumm/view

Campbell, D., Marsh, S. and Bannock, C. (2020, July 1). London hospitals struggle to cope with coronavirus surge. *The Guardian*. https://www.theguardian.com/uk-news/2020/mar/20/london-hospitals-struggle-to-cope-with-coronavirus-surge

Chamberlain Dunn (2020). ESTEEM: One person, one hand, one heart. *Chamberlain Dunn*. https://chamberlaindunn.co.uk/esteem-one-person-one-hand-one-heart/

Everly, G. (2020). Psychological First Aid. *Johns Hopkins University*, hosted on Coursera. https://www.coursera.org/learn/psychological-first-aid

Glaspey, L. J., Roberts, M. B., Mazzarelli, A., Trzeciak, S., Roberts, B. W. (2017) Early interventions for the prevention of post-traumatic stress symptoms in survivors of critical illness: protocol for a systematic review. *BMJ Open* 7:9. doi:10.1136/ bmjopen-2017-018270

Kubler-Ross, E. (1969). *On death and dying*. Macmillan.

North London Music Therapy (2020a) Music for mental health with a COVID-19 doctor. YouTube, viewed 16th June 2020 https://www.youtube.com/watch?v=sW9BB2X6Lso

North London Music Therapy (2020b). Meet Sarah. You'll want the sound on for this one. Tweet, 20th April 2020, viewed 16th June 2020 https://twitter.com/NLmusictherapy/status/1252130421900480513

Parkes, C. M. (2009). *Love and loss: The roots of grief and its complications*. Routledge.

Rizkallah, M. (2020). BAMT Guidance for music therapists during the COVID-19 outbreak. https://www.bamt.org/about-british-association-for-music-therapy/covid-19-useful-information/bamt-guidance.html

Winnicott, D. W. (1962). The theory of the parent-infant relationship. *International Journal of Psychoanalysis, 43*, 238-239.

Worden, J. W. (1983). *Grief counselling and grief therapy* (1st ed.). Tavistock.

Ελληνική περίληψη | Greek abstract

Η Τηλεφωνική Υπηρεσία Υποστήριξης του North London Music Therapy για το προσωπικό της Εθνικής Υπηρεσίας Υγείας κατά τη διάρκεια της πανδημίας COVID-19: Μια αναφορά της υπηρεσίας και τη σημασίας της για το επάγγελμα της μουσικοθεραπείας

Marianne Rizkallah

ΠΕΡΙΛΗΨΗ

Το Μάρτιο του 2020, οι αναφορές έδειξαν ότι το προσωπικό της Εθνικής Υπηρεσίας Υγείας (NHS) του Ηνωμένου Βασιλείου αντιμετώπισε σημαντική πίεση σχετικά με την περίθαλψη ασθενών με COVID-19. Οι μουσικοθεραπευτές διαθέτουν δεξιότητες που μπορούν να προσφέρουν σχετικά με τη θεραπεία στην ψυχική υγεία: αυτή η αναφορά περιγράφει το πώς ο οργανισμός North London Music Therapy (NLMT) σχεδίασε και υλοποίησε μια νέα Τηλεφωνική Υπηρεσία Υποστήριξης παρέχοντας οξεία υποστήριξη, αντί θεραπείας, μέσω τηλεφώνου στο προσωπικό του NHS, ξεκινώντας τρείς εβδομάδες νωρίτερα από τη γραμμή τηλεφωνικής υποστήριξης του ίδιου του NHS. Σε αυτή την αναφορά θα παρουσιαστεί η διαδικασία εγκαθίδρυσης της υπηρεσίας και θα εξεταστούν τα κίνητρα πίσω από την ανάπτυξη αυτής. Το NLMT έλαβε αυτοπαραπομπές από όλο το Ηνωμένο Βασίλειο, με το 50% των παραπομπών να δέχονται αρχική τηλεφωνική επικοινωνία και το 50% αυτών να ολοκληρώνουν τρεις τηλεφωνικές συνεδρίες υποστήριξης. Το NLMT έλαβε 100% θετική ανατροφοδότηση από όλους τους συμμετέχοντες, όπως σηματοδοτήθηκε αποτελεσματικά στο τέλος της υπηρεσίας. Το NLMT είναι υποψήφιο για το βραβείο Advancing Healthcare ESTEEM για την Τηλεφωνική Υπηρεσία Υποστήριξης, λόγω της ταχύτητας με την οποία ιδρύθηκε και λόγω των παρεχόμενων υπηρεσιών του στους βασικούς εργαζόμενους στην πρώτη γραμμή της κρίσης του κορονοϊού. Η υπηρεσία εξακολουθεί να είναι διαθέσιμη, αλλά τώρα που το NHS έχει ξεκινήσει τις δικές του εσωτερικές υπηρεσίες υποστήριξης, η εστίαση του NLMT έχει πλέον προσανατολιστεί στην φροντίδα που έπεται της οξείας υποστήριξης για τους βασικούς εργαζόμενους και τους οργανισμούς στους οποίους εργάζονται.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

COVID-19, ψυχική υγεία, ψυχολογικές πρώτες βοήθειες, τηλεφωνική υπηρεσία, μουσικοθεραπεία

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REPORT

Special Feature | Reports on online music therapy

Adapting practice during the Covid-19 pandemic: Experiences, learnings, and observations of a music therapist running virtual music therapy for trafficked women

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ABSTRACT

This report describes a 10-week, hybrid face-to-face/virtual pilot project that was run in a safehouse in the south of England for women who had been rescued from human trafficking. Due to the implementation of Covid-19 pandemic restrictions, the final three sessions of the pilot project were run online via video conferencing technology (Skype). Outcomes of the project suggested that, while there were challenges, running online sessions was beneficial and better than not offering any music therapy at all. Continued contact and the provision of a safe, therapeutic space was highly valued. This report explores the benefits and challenges of running music therapy in a virtual environment versus music therapy in a face-to-face environment.

KEYWORDS

virtual music therapy,
trafficked women,
covid-19,
therapeutic presence,
communication,
interaction,
language barriers,
containment,
musical holding

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REHABILITATION OF SURVIVORS OF HUMAN TRAFFICKING

Rehabilitation for survivors of international human trafficking is a complex process. Having escaped their abusive situation, they face a myriad of new problems that come with being displaced, such as facing loss, adjusting to a new culture and language, and navigating the systems of the country in which they find themselves, as well as dealing with severe trauma. There is also uncertainty about the

future as they wait for the government to decide whether they can remain in the country. Building relationships and establishing themselves in the community is consequently very difficult. Minimal financial resources add to this challenge and restrict their ability to build social networks or to improve prospects through education or training. In the UK, the majority of asylum seekers do not have the right to work (Home Office, 2019). The ability to cope with day-to-day life and recovery may be slowed down due to re-traumatisation as they undergo police investigations, and the estimated rate of re-trafficking and exploitation is still high (Jobe, 2010). The lack of stability, uncertainty of the future and fragile physical and mental health means that there is a real need for therapeutic, trauma-informed intervention and aftercare (Hemmings et al., 2016).

THE PROJECT

The 10-week pilot project began in January 2020, as an open group in a safehouse for women who were recently rescued victims of human trafficking, primarily involving domestic servitude and sex trafficking. The project was designed to determine if music therapy could be an effective intervention, in a service in which there was a frequently changing cohort of clients and in which the women in residence had been severely traumatised.

Due to the transient nature of the setting, the decision was made to run the project as a non-compulsory open group. The main aims were: 1) To create a feeling of belonging and togetherness, 2) To allow residents to find their place within a group and to become confident to express themselves, 3) To build positive, mutually supportive relationships with others and finally, 4) To build inner resilience through shared musical experiences. Due to the Covid-19 pandemic the work was interrupted which meant that the project had to be completed virtually. Providing a positive experience of ending was crucial for the women who attended, since they would have experienced significant disruption to their lives as a result of their situation. Sessions consisted of an opening activity (playing an instrument that was passed round to say hello), a drumming section, an improvisation section, a relaxation, and deep breathing section leading to vocalising, and finally playing an instrument that was passed round to say goodbye. A significant portion of the group time was given to structured improvisation, as transferences of anxiety and vulnerability were felt when improvisations were left completely 'open', showing a need for the group to feel more 'held.' The improvisatory portion of the project was adapted once sessions were moved online.

THE CHALLENGES

When transitioning from face-to-face sessions to sessions conducted virtually, a number of challenges became apparent as follows:

1. Reliability of the audio

The group met in their usual therapy room using one laptop and the therapist ran the sessions via a laptop from a private space in a different location. Unfortunately, the sound was found to be unreliable meaning that the group had to strain to listen if the therapist moved too far from the screen.

2. Difficulty with multiple, simultaneous audio sources

The audio worked well when the therapist talked exclusively, but multiple layers of sound (e.g. group musical improvisations) did not work well as they did not produce the sound quality needed to provide an adequate musical holding due to breaks and delays. This paralleled observations from the pre-virtual portion of this pilot project that indicated that the women found it challenging 'to be with' each other musically and to listen and respond to each other's music.

Austin (2001) suggests that when working with recently traumatised clients, it is vital that the music is stable and consistent in order to provide safety where there is potential for repairing the connection between self and others. The same author writes specifically of vocal holding techniques, a method of vocal improvisation using two chords and the therapist's voice that provides a

> […] reliable, safe structure for the client who is afraid or unused to improvising; it [the vocal holding technique] supports a connection to self and other and promotes a therapeutic regression in which unconscious feelings, sensations, memories and associations can be accessed, processed and integrated (Austin, 2001, p. 7).

If musical holding is interrupted through poor sound relay, it sabotages the therapeutic process.

3. Needing to adapt to a virtual environment

During the face-to-face portion of the project, the free improvisations were often fragmented and chaotic with some moments of cohesion that increased in frequency as the therapy progressed. The music reflected the dynamics in the house where there was a sense of fragmentation and separation, with residents from varied cultural backgrounds and speaking different languages recovering from their unique story of trauma and navigating their own, personal pathway to recovery. When moving the project online, adapting the content to focus more on turn-taking had the benefit of encouraging the women to listen and respond to each other accordingly.

4. Therapeutic presence

When thinking about how to run the sessions virtually, I decided to ask a staff member to be present for the duration of the session (it was decided that the house manager would attend all remaining sessions as a consistent member of staff. Additionally, a second manager participated in the final session). It was hoped that as well as providing technical assistance if needed, a staff member who was a familiar and consistent presence in the house could assist in containing any difficult emotions that arose from the group as well as assist with any communication lost through the limits of technology. This helped clients feel safe which was of paramount importance as trauma causes a deep wounding that "renders useless the protective filtering processes through which we have come to feel safe in the world" (Sutton, 2002, pp. 23-24).

Some additional questions arose as well. To what extent is it possible to contain emotions when one is removed physically? Is an on-screen presence less nurturing than a physical presence and if so, how does that impact on the experience of the participants? Which aspects of the therapeutic

relationship are limited by therapy that is conducted virtually? Malchiodi (2020, p.100) writes "Establishing safety and providing strategies for self-regulation form the foundations of effective trauma-informed intervention, but the psychotherapeutic relationship remains the central factor in reparation."

5. Non-verbal responses to treatment

Running music therapy in a virtual environment, when compared to a face-to-face environment may, to a degree, hinder the therapeutic relationship. For example, containing emotions felt more difficult due to being restricted in being able to use the full range of communicative tools, as compared to what is possible when physically present (e.g. coming to sit beside the client to show empathy). Picking up on the subtle nuances of subconscious communication, such as body language and facial expression, and matching that to felt emotional content was also more challenging. Overall, I felt that there was less accurate 'material' to work with when viewing and listening through a computer screen. Research involving technologies such as Zoom and Skype, describes an "inability to read nonverbal cues as a result of inconsistent and delayed connectivity" (Archibald et al., 2019, p. 2) as an issue in virtual communication. The transition to virtual music therapy later on in the project necessitated more of a dependence on the staff member and her ability to communicate authentically with the participants. My role as the therapist became more about the simplicity of providing a continuous service and a way of being together. It became more about shaping the direction of the group, providing the structure and means to interact, relate, and communicate, while being less able to 'be with' the group in a way that was as effective as in face-to-face sessions. I felt a strong sense of separation and was acutely aware of the two-dimensional nature of virtual interaction. This was exaggerated by the language barriers where communication was already a challenge and the women relied more heavily on the wider, non-verbal aspects of communication.

ADAPTING GROUP STRUCTURE

Due to the music therapy protocol being largely improvisation-based, moving the sessions to a virtual environment meant having to re-think the structure of the sessions. As such, the content was adjusted accordingly. The changes were as follows:

a) Lengthening the relaxation/deep breathing section as deep breathing promotes relaxation by helping to slow the heart rate, calming the nervous system and therefore the mind and the body (Orth, 2005). This seemed valuable to reduce any anxiety that may be heightened due to the pandemic.
b) More use of visuals to help explain concepts.
c) Preparation of a home programme resource with some music therapy informed activities to improve clients' mental health, reduce anxiety and the impact of the trauma they had experienced.
d) Increasing the time spent on the drumming section with more focus on call-and-response rather than playing at the same time.

e) Creation of a "thank you" and "goodbye" song that was sung to each individual during the final session with time spent to affirm each participant. Participants were also offered an opportunity to respond and express how they felt about the music therapy ending.
f) A "thank you" card was given to each participant who had ever attended the project. The later addition of the "thank you" card (which was thought about in light of the project having to be completed virtually) acted as a transitional object to mark the ending of the therapy in the physical absence of the therapist. This may have further enhanced the participants' positive feelings towards the therapy as they felt thought about and valued beyond the end of the sessions.

EVALUATING THE PROJECT

Evaluations at the end of the project took place in the form of a survey for clients with a blend of open questions and rating scale questions. The same survey was given to the two members of staff who participated. While language barriers prevented in depth commentary from the majority of clients, feedback was all positive and revealed that the music therapy was both enjoyable and of therapeutic benefit to them. Clients did not distinguish between face-to-face and virtual music therapy but commented on the project as a whole. In hindsight, comparative surveys of the two distinct sections of the music therapy could have been useful. Staff feedback affirmed the value of running the final sessions via Skype so that provision could continue and that while running the group virtually was not ideal, it was better than no music therapy at all.

FINAL THOUGHTS

Communication and its multi-faceted nature, a central tenet of any music therapy work, was particularly highlighted during this pilot project, as the clients came from a range of cultural backgrounds and spoke languages with which the therapist was not familiar. Additionally, the severe trauma experienced by the women affected the way they interacted with their environment. Therefore, the provision of a safe and holding therapeutic environment was critical to the work. The experience of running the remaining three sessions virtually exaggerated these challenges and meant that it was necessary to adapt rapidly and creatively to meet the need in a way that was of most value to the participants, while avoiding a sudden termination of the therapeutic relationship. It also meant that the role of the therapist was altered, with more emphasis on facilitation. The philosophical and practical concept of the importance of a therapeutic presence was emphasised, particularly in a group context.

Further research on the effectiveness of prolonged virtual communication, versus face-to-face therapeutic interventions, is necessary to ensure that best practices are identified that are specific to the type of intervention that is being used (virtual or face-to-face) in order to refine future music therapy protocols. As this pilot project shows, there remains new areas of clinical need which can benefit from the practice of music therapy and push the music therapy profession to greater heights of innovation and adaptability, while increasing our understanding of the therapeutic process.

REFERENCES

Archibald, M. M., Ambagtsheer, R. C., Casey, M. G., & Lawless, M. (2019). Using Zoom videoconferencing for qualitative data collection: Perceptions and experiences of researchers and participants. *International Journal of Qualitative Methods*, *18*. https://doi.org/10.1177/1609406919874596

Austin, D. (2001). In search of the self: The use of vocal holding techniques with adults traumatized as children. *Music Therapy Perspectives*, *19*(1), 22-30. https://doi.org/10.1093/mtp/19.1.22

Hemmings, S., Jakobowitz, S., Abas, M., Bick, D., Howard, L. M., Stanley, N., Zimmerman, C., & Oram, S. (2016). Responding to the health needs of survivors of human trafficking: A systematic review. *BMC health services research*, *16*(1), 1-9. https://doi.org/10.1186/s12913-016-1538-8

Home Office (2019). Permission to Work and Volunteering for Asylum Seekers version 8.0. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/945926/permission-to-workandvolunteering-for-asylum-seekers.pdf

Jobe, A. (2010). The causes and consequences of re-trafficking: evidence from the IOM Human Trafficking Database. http://publications.iom.int/bookstore/index.php?main_page=product_info&cPath=41_7&products_id=684

Malchiodi, C. A. (2020). *Trauma and expressive arts therapy: Brain, body, and imagination in the healing process*. Guilford Press.

Orth, J. (2005). Music therapy with traumatized refugees in a clinical setting. *Voices: A World Forum for Music Therapy*, 5(2). https://doi.org/10.15845/voices.v5i2.227

Sutton, J. P. (Ed.). (2002). *Music, music therapy and trauma: International perspectives*. Jessica Kingsley Publishers.

Ελληνική περίληψη | Greek abstract

Προσαρμόζοντας τη θεραπευτική πρακτική εν μέσω της πανδημίας Covid-19: Εμπειρίες, μαθήματα και παρατηρήσεις μίας μουσικοθεραπεύτριας από την προσφορά διαδικτυακής μουσικοθεραπείας με γυναίκες θύματα εμπορίας ανθρώπων

Lorraine McIntyre

ΠΕΡΙΛΗΨΗ

Η παρούσα αναφορά περιγράφει ένα υβριδικό πρόγραμμα 10 εβδομάδων όπου πραγματοποιήθηκαν δια ζώσης και διαδικτυακές συνεδρίες σε ένα καταφύγιο στη νότια Αγγλία για γυναίκες που είχαν διασωθεί από κύκλωμα εμπορίας ανθρώπων. Λόγω των περιορισμών που εφαρμόστηκαν για την πανδημία Covid-19, οι τρεις τελευταίες συνεδρίες του πιλοτικού προγράμματος πραγματοποιήθηκαν μέσω διαδικτυακής τηλεδιάσκεψης (Skype). Από τα αποτελέσματα του προγράμματος προκύπτει ότι, παρ' όλες τις προκλήσεις, η διενέργεια διαδικτυακών συνεδριών ήταν ωφέλιμη και προτιμότερη από τη γενική παύση της μουσικοθεραπείας. Η συνεχιζόμενη επαφή και η παροχή ενός ασφαλούς θεραπευτικού χώρου εκτιμήθηκε ιδιαίτερα. Αυτή η αναφορά διερευνά τα οφέλη και τις προκλήσεις διεξαγωγής μουσικοθεραπευτικών συνεδριών μέσω ενός διαδικτυακού περιβάλλοντος σε αντιπαράθεση με τις δια ζώσης συνεδρίες.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

διαδικτυακή μουσικοθεραπεία, γυναίκες θύματα εμπορίας ανθρώπων, covid-19, θεραπευτική παρουσία, επικοινωνία, αλληλεπίδραση, γλωσσικά εμπόδια, περίεξη [containment], μουσικό κράτημα

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ARTICLE

Knowledge and training of Orff-based music therapy among students, clinicians, and educators

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ABSTRACT

The purpose of this research study was to examine knowledge and training of Orff-based music therapy among music therapy students, clinicians and educators using a variety of demographic, training, and outcome variables. The measurement tool was an online survey designed to satisfy this primary purpose and seven associated research questions targeting: (1) Demographics, (2) Definitions, (3) Training, (4) Professional Development, (5) Clinical Practice, (6) Treatment Outcomes, and (7) Professional Competencies. Basic descriptive statistics were provided through SurveyMonkey, although the researcher condensed provided narrative content as needed to present summarised text responses. Results and Discussion are organised around these seven primary research questions, with Implications for Training and possibilities for Future Research included. In summarising just a few pertinent results, 56% of the 262 survey respondents indicated having training in Orff-based music therapy within their academic programme. One hundred and four respondents (39.7% of 262) said they used it in their clinical practice and 95.4% thought it could be effective within the social domain. Respondents felt the following professional competencies could be addressed through training in the Orff process for student music therapists: transpose simple compositions; compose songs with simple accompaniment; adapt, arrange, transpose and simplify music compositions for small vocal and nonsymphonic instrumental ensembles; utilise basic percussion techniques on several standard and ethnic instruments; and improvise on pitched and unpitched instruments, and vocally in a variety of settings including individual, dyad, small or large group.

KEYWORDS

Orff-based,
music therapy,
survey

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INTRODUCTION

"A survey is a systematic method of collecting data from a population of interest" (Health Communication Unit at the Centre for Health Promotion, 1999, p. 1) and disseminated through two primary forms of information gathering, namely questionnaire and interview. The decision of what form to use depends upon the respondent population and questions being asked of respondents.

Primary steps in completing a survey include: (a) determining purpose of research, (b) assessing resources, (c) deciding which form to use, (d) writing survey questions, (e) pilot-testing the survey, (f) preparing the sample, (g) training interviewers if appropriate, (h) collecting data, (i) processing data, (j) analysing data, (k) interpreting and disseminating results, and (l) taking action as a result of findings (Health Communication Unit at the Centre for Health Promotion, 1999). For the current survey, the population of interest was those involved in the practice of music therapy, including student music therapists, burgeoning as well as experienced clinicians, and those involved in academic training. Data collected through this systematic method were related to the Orff Schulwerk process specifically within the context of music therapy clinical practice. The intent of this survey was to examine knowledge and training of Orff-based music therapy among music therapy students, clinicians, and educators (defined as faculty staff teaching music therapy at the university level) as a springboard for creation of music therapy clinical training protocols involving Orff Schulwerk and implementation of intervention-based research using the Orff process. Before beginning such endeavours, the researcher felt it pertinent to determine what is the current knowledge and training of the listed respondent groups.

Carl Orff's Schulwerk is a process to teach music and build musicianship based on activities children like to do: singing, saying, moving, and playing. Learning occurs by first hearing/making music followed naturally by reading/writing music that has been heard or created; somewhat comparable to how children learn language. Imitation, experimentation, and personal expression are essential elements of the process as children are active participants in creative music-making intended to develop the *whole* person while specifically impacting social-emotional and cognitive growth ("More on Orff Schulwerk," 2019).

Educational, clinical, and research literature has described the use of the Orff Schulwerk process for music and non-music domains in both music education and music therapy settings. In the United States, this literature chiefly resides within the American Orff-Schulwerk Association's (AOSA) journal, *The Orff Echo* (Colwell, 2020), although additional manuscripts (Hilliard, 2007; Perlmutter, 2016) are found across other disciplines in both trade and research journals nationally and internationally. Published literature has focused on using the Orff process in music education settings with children and youth with special needs, as well as across the lifespan from early intervention through older adults in community settings (i.e. Dakin, 2015; Ernst, 2003; Maltas & Pappas, 2005; McCord, 2012; McCord & Rogers; 2010; Miller, 2013; Opelt, 2015; Richardson, 2003; 2008; Sain et al., 2013; Siebenaler, 2014). A primary focus of many articles is use of the Orff process when teaching students with special needs in the elementary music classroom (Bessinger, 2005; McCord, 2012; McCord & Rogers, 2010; Miller, 2013; Perlmutter, 2016; Sain et al., 2013; Thomforde, 2018). Somewhat at the opposite end of the developmental spectrum, the Orff process has been successfully adapted for working with older adults (Dakin, 2015; Ernst, 2003; Maltas & Pappas, 2005; Opelt, 2015; Richardson, 2003; 2008) as well as diverse age groups in intergenerational settings (Sabourin, 2000; Shotwell, 1985). To exemplify targeted populations, authors discuss using Orff Schulwerk in the English as a Second Language (ESL) classroom (Lewis, 2015; Whitley, 2013), with students with attention-deficit disorder (Siebenaler, 2014), for individuals with hearing loss (Salmon, 2013), and those impacted by tragedy or loss (Beegle & Campbell, 2002).

In addition to the focus in music education, literature exists that is specifically attentive to adaptation of the Orff process to music therapy in both traditional and unique therapeutic settings. Based on the Orff Schulwerk approach, Orff-based music therapy was developed in clinical settings in Germany by Gertrud Orff while targeting emotional development when working with children with developmental disabilities. Her intent was not to teach them music but to support their development, most particularly their self-concept, through interacting with their environment within active, creative music-making (Voigt, 2013). She felt that Schulwerk (meaning 'School Work') could be easily adapted to working with those with special needs in a therapeutic environment due to four primary characteristics: (a) elemental music encompasses word, sound, and movement and as such a whole-body/whole-music experience, (b) opportunities for structured and free improvisation exist consistently, (c) the *instrumentarium* is diverse and adaptable for inclusivity of those with varied abilities, and (d) music is inherently multisensory (Orff, 1989; Voigt, 2003, 2013). By its very nature, the Schulwerk allows everyone to participate, begins where the individual is at developmentally, uses culturally relevant material, includes success-oriented experiences, and focuses on process rather than solely product of the musical experience (Bitcon, 2000; Colwell, 2005, in progress; Colwell et al., 2008).

Targeting non-music domains with children with special needs has been the concentration of several individuals using Orff from a special music education or music therapy perspective (Bessinger, 2005; Bonkrude, 2005; Gadberry, 2005; Furman & Kaplan, 2011; Kaplan, 2005). Expanding beyond school-based children with special needs, Hilliard (2007) and Register (Register & Hilliard, 2008) integrated Orff Schulwerk in their work in hospice and bereavement care while others used the Orff process to develop coping strategies with adolescents in a child psychiatric unit (Shain, 2011) and to decrease anxiety in student music therapists (Detmer, 2014). Colwell and collaborators have described Orff-based music therapy (Colwell, 2005) and examined the Orff process with students with Traumatic Brain Injury (Colwell, 2012), communication challenges (Colwell, 2016), and those in paediatric hospitals (Colwell, 2009; Colwell et al., 2013), as well as investigated the impact of training in Orff Schulwerk on the development of music therapy session plans (Colwell & Edwards, 2010), and as supportive cancer care with adults (Colwell & Fiore, in press).

Although clinical reports and research focused on the topic of Orff-based music therapy are available, much of it is not published in the American Music Therapy Association's (AMTA) primary journals; therefore this researcher was interested in determining what music therapy students, clinicians, and educators know about this topic. Consequently, the purpose of this research study was to examine knowledge and training of Orff-based music therapy among music therapy students, clinicians, and educators by answering the following seven research questions.

Research question 1: Demographics: What are demographics of individuals who chose to respond to this survey? (gender, role [student, educator, clinician], years in the profession, credentials, geographic region of residence, education, and clinical training)

Research question 2: Definitions: How do respondents define both the Orff Schulwerk process and Orff-based music therapy?

Research question 3: Training: a) Do respondents have Orff training in their academic programme or clinical internship experience? b) Do respondents have Orff training approved by the American Orff-Schulwerk Association (AOSA)? If so, what level of training? and c) If respondents are educators, do they teach Orff-based music therapy?

Research question 4: Professional development: Have respondents participated in Orff professional development through AMTA regional or national conferences or through state workshops or AOSA national conferences?

Research question 5: Clinical practice: Do respondents use Orff-based music therapy in their clinical practice (media, instrumentation, resources)? If so, how?

Research question 6: Treatment outcomes: In what domains do respondents think Orff-based music therapy could be effective? If so, how? Within those domains, what outcomes do respondents think could be best addressed through Orff-based music therapy?

Research question 7: Professional competencies: Based on respondents' knowledge of Orff-based music therapy, which professional competencies under Music Foundations do respondents think could be addressed through training in the Orff process for the student music therapist? Which three are considered most likely to be addressed?

METHOD

Survey design

After creation of an initial draft, the survey was disseminated to three individuals who have extensive knowledge of Orff Schulwerk. Each expert took the survey, logged the time it took for completion, and provided feedback on survey questions with needed additions, deletions, or modifications. The researcher assimilated this information in a second and final iteration of the survey to be sent for HRPP approval and subsequent dissemination. The survey consists of seven primary parts: (1) Information statement, (2) Demographics and training, (3) Orff training, (4) Conferences and workshops, (5) Clinical practice, (6) Treatment outcomes, and (7) Professional competencies: Music foundations.

Part 1 is the required information statement. Parts 2 through 4 focused on participants' demographics, knowledge, training and experience. Part 2 asked for demographics including gender, years as a music therapist, credentials, and regions of residence, academic training, and clinical training. Part 3 inquired as to completion of and potential knowledge acquired from Orff training and asked participants to define the Orff Schulwerk process and briefly write what they know about Orff-based music therapy. To determine engagement in Orff training, participants were asked whether they had opportunities during academic or clinical training or if any respondents held Orff certification. If respondents self-identified as educators, they were asked if they teach Orff-based Music Therapy and, if so, to further describe their method and/or content of teaching. Part 4 ascertains whether respondents attended sessions focused on Orff at conferences of AMTA or the American Orff-Schulwerk Association (AOSA), participated in local or state Orff workshops, and whether respondents were members of AOSA. If respondents attended conference sessions or workshops, they were asked to briefly describe topics covered in these opportunities.

Parts 5 through 7 focused more on clinical practice of Orff-based music therapy and its potential impact on treatment outcomes and student music therapist training. Part 5 determined if respondents used Orff-based music therapy in their clinical practice, incorporated traditional Orff media (i.e. body percussion) or barred percussion instruments, and asked where respondents obtained Orff orchestration resources. Based on respondents' understanding of Orff-based music

therapy, Part 6 investigated which domains participants thought could be impacted by this process and what treatment outcomes could be successfully addressed. Part 7 concluded the survey by asking respondents to indicate which AMTA Professional Competencies within Music Foundations could be addressed through the Orff process.

Recruitment and informed consent

After approval from the university-affiliated *Human Research Protection Program* (HRPP), the researcher requested and purchased email addresses from the *American Music Therapy Association* (AMTA) as is permitted for research purposes. Potential participants were sent an email with the following information: researcher background and interest in topic, explanation of the study and its purpose, and a link to an online survey through SurveyMonkey. The first section of the survey was an information statement required by the HRPP to support the practice of protection for human subjects participating in research. Participants were notified that if they completed the survey, that action implied informed consent.

Participants

Participants were student and professional members of the American Music Therapy Association (AMTA). An initial list of 3,510 emails was obtained from AMTA for survey dissemination. Due to server limitations, emails were sent in 35 batches of approximately 100 emails per batch. From this initial dissemination, 78 emails came back as no longer valid, five came back with an 'out of office' reply, one respondent asked to be removed from this mailing, one indicated no longer working as a music therapist, and four reported no knowledge of Orff so felt it best not to respond. The researcher removed her own address from the list, dropping the number of possible respondents to 3,420. From this revised number, 383 initiated the survey, indicating an 11% initial response rate. Further information regarding respondents is reported in the Results section of this manuscript.

Procedures

HRPP and AMTA research approvals were obtained as described above in Recruitment and Informed Consent. Approximately one month and again two months after the initial email was sent, a second, and then a third and final reminder email request for survey completion was sent to all respondents. The survey was left open for those who had not yet had the opportunity to complete the survey, but might like to complete it at their convenience. The survey was closed at the six-month mark following initial request. Average survey completion time for those who completed the entire survey was approximately 17 minutes.

Data security

Due to the nature of this online format, surveys submitted through SurveyMonkey came to the researcher with no identifiable personal information associated with results other than an IP address. This IP address was deleted when participants were assigned a respondent number.

SurveyMonkey responses were accessible only to the researcher as results were secured by a researcher-created username and password. Data were entered in SPSS on the desktop computer of the researcher's password-protected computer, kept in a locked university office.

Survey data analysis

Participants completed the survey with responses submitted through SurveyMonkey. The measurement tool was the survey, and data were responses to survey questions. Basic descriptive statistics were provided through SurveyMonkey; although the researcher condensed provided narrative content as needed to present summarised text responses. The researcher and reliability coder each examined all narrative comments with reliability calculated as [(Agreements)/(Agreements + Disagreements)x100] = percentage of agreement.

RESULTS

The results section is organised around the seven research questions listed in the Introduction section. Each research question has been abbreviated to the heading that describes the information obtained from the survey related to that particular research question.

Demographics

A total of 383 participant respondents started the questionnaire. Five incomplete responses were eliminated as they had the same IP address and identical demographics to five completed survey attempts. An additional 51 survey respondents with incomplete responses dropped out of the survey after the *Demographics and Training* section with an additional 10 dropping out near the start of the *Clinical Practice* section. Forty-eight more respondents dropped out near the start of the *Treatment Outcomes* section, with seven respondents leaving the survey at the start of the final section, *Professional Competencies: Music Foundations*. This left a total of 262 completed surveys.

Table 1 depicts information from 262 respondents who completed the survey, targeting gender, years in the profession, credentials, and geographic region of current residence, academic training, and clinical internship training. All 262 respondents answered each question under the *Demographic and Training* section, except gender. As was permissible on the survey, two opted not to respond and one placed a checkmark for each gender, male and female. Participants were asked, if willing, to indicate which school they attended for academic training. Although not listed in Table 1 due to the amount provided, a total of 68 different universities were listed, with 193 (73.7%) of 262 respondents listing a school in this text box. Three schools with the most respondents were University of Kansas (40), Florida State University (11), and Michigan State University (7).

Question (total number of respondents *N*/%)	Category	*N* participants who responded to individual question	% participants who responded to individual question
Gender (260/99.2%)	Female	**231**	**88.2%**
	Male	28	10.7%
	Other (checked both)	1	0.4%
	No response	2	0.8%
Years in Profession (262/100%)	Still in school/Student	30	11.5%
	Less than 5 years	**73**	**27.9%**
	5-10 years	31	11.8%
	11-15 years	27	10.3%
	16-20 years	22	8.4%
	21-25 years	22	8.4%
	More than 25 years	57	21.8%
Credentials (262/100%)	Still in school/Student	30	11.5%
	MT-BC	**221**	**84.4%**
	CMT	3	1.1%
	RMT	7	2.7%
	MT-BC/RMT	1	0.4%
Geographic Region of Residence (262/100%)	Mid-Atlantic	46	17.6%
	Midwest	49	18.7%
	Great Lakes	**52**	**19.8%**
	Southwestern	17	6.5%
	Southeastern	45	17.2%
	New England	12	4.6%
	Western	28	10.7%
	International Member	12	4.6%
	Other*	1	0.4%
Geographic Region of Academic Education (262/100%)	Mid-Atlantic	48	18.3%
	Midwest	**78**	**29.8%**
	Great Lakes	39	14.9%
	Southwestern	13	5.0%
	Southeastern	42	16.0%
	New England	8	3.1%
	Western	17	6.5%
	International Member	2	0.8%
	Other**	15	5.7%
Geographic Region of Clinical Internship Training (262/100%)	Mid-Atlantic	**56**	**21.4%**
	Midwest	38	14.5%
	Great Lakes	53	20.2%
	Southwestern	23	8.8%
	Southeastern	36	13.7%
	New England	10	3.8%
	Western	30	11.5%
	International Member	2	0.8%
	Still in school (pre-internship)	14	5.3%

** 15 of the 262 participant respondents indicated more than one region of residence

Table 1: Respondent demographics and training

Definitions

Of the 262 respondents, 99 indicated either "I don't know" or N/A when asked to define the Orff Schulwerk process in music education, while 75 indicated the same when asked to define Orff-based music therapy. The researcher's primary intent of asking for these definitions was for the respondents to contextualise their survey responses by considering how they personally define these terms. Examination of the supplied definitions indicates the most common words within the definition of Orff Schulwerk were 'music' and 'instruments' and the most common phrase being 'A method of teaching'. Comparable examination of the definition of Orff-based music therapy found the most common words being 'music' and 'Orff', and the two most common phrases being 'To achieve non-musical goals' and 'Use of Orff instruments'. Sample definitions from respondents were:

The definition of Orff Schulwerk process in music education is:

- folk-based, elemental and organic way of teaching and learning music.
- the use of simple instruments to create a complex musical experience.
- the use of rhythm, speech and movement to encourage creativity.
- that there are a number of fundamental aspects of Orff - in each country where it is implemented, the music at its foundation is the folk music of that country, it uses specially designed instruments that are accessible and adaptable, it stresses the importance of body percussion and movement, it relies on a scaffolding of skills to teach concepts and music, it is experiential.

The definition of Orff-based music therapy is:

- to use the Orff process as a way of engaging with music/music learning/improvisation; other music therapy goals may be met, but this is how the engagement happens in the music.
- the use of Orff instruments using the pentatonic scale, voice and movement to create music and encourage self-confidence and self-expression.
- a collaborative music experience that uses progressively accessible musical containers, movement, and progressively accessible instrumentation to promote health-oriented goals.
- a highly interactive and engaging method involving use of selected and prescribed materials of the Orff Schulwerk approach in the context of a therapeutic relationship with the music therapist to address the clinical domains and to meet the client's assessed needs.

Training

When inquiring about Orff training, approximately 56% (146) of all participant respondents indicated that they had experienced Orff training in their academic programme (see Table 2 for results related to training). Of these 146 respondents, 112 chose to expand with a narrative response, with 126 different academic experiences related to Orff listed in the comments. Fifty-six listed specific experiences were within academic coursework, with 21 of those 56 having semester-long courses

specifically targeting Orff-based music therapy. Twenty-two listed general or brief information embedded in a methods course, while four stated they had training but were not specific as to what or where. Three participated in an Orff ensemble, and 14 said they played Orff instruments in classes. Twelve indicated they completed a Level 1 Orff teacher training course, one a Level 2 course, and eight attended an Orff-focused workshop during their academic programme matriculation. Three said they completed readings about Orff for coursework, and three indicated they had trained with Carol Bitcon, a well-known music therapist and clinical training director who was an Orff specialist (83% reliability between content coders).

Question (total number of respondents *N*/%)	Category	*N* participants who responded to individual question	% participants who responded to individual question
Orff training in academic programme (262/100%)	**Yes**	**146**	**55.7%**
	No	116	44.3%
Orff training in clinical internship (262/100%)	Yes	23	8.8% (9.3% post intern)
	No	**225**	**85.9% (90.7% post intern)**
	N/A (pre-internship)	14	5.4%
Orff training approved by AOSA (262/100%)	Yes	45	17.2%
	No	**217**	**82.8%**
Yes to AOSA approved training (45/100%)*	**Level 1**	**38**	**84.4%**
	Level 2	10	22.2%
	Level 3	7	15.6%
	Master Class	6	13.3%
	Apprentice	0	0%
Teach Orff-based music therapy (60/100%)	**Yes**	**30**	**11.5% (50% of educators)**
	No	**30**	**11.5% (50% of educators)**
	N/A; not educator	202	77.1%

*note that only 45 participant respondents answered this question, and percentages can be greater than 100% as each respondent could indicate more than one option

Table 2: Training in and teaching of Orff Schulwerk

Removing participant respondents who had not yet completed their clinical internships (14 of 262), only 9.3% (23) of the remaining 248 respondents indicated training within their internship experience. These 23 respondents plus two others, who originally indicated no training, chose to respond to the narrative question and described Orff experiences during their clinical internship. Eight stated they used Orff instruments, five addressed concepts related to Orff Schulwerk, seven attended weekend workshops, one completed Level 1 Orff certification, and four had training with Carol Bitcon (100% reliability between content coders).

Two hundred and seventeen (82.8%) respondents indicated that they did not have any specific AOSA-approved training in Orff Schulwerk, while 45 (17.2%) said that they did. Teacher training in Orff Schulwerk through AOSA-approved courses consists of three levels that must be taken sequentially, followed by an optional extended Master Class and then an apprenticeship opportunity to become an official teacher trainer. Due to this stair-stepping process, the overall percentage response for this question equals more than 100% as the 45 individuals who indicated they had specific training could indicate completion of more than one level.

Of the 262 respondents, 60 indicated that they were educators with exactly half (30) stating that, yes, they do teach Orff-based music therapy, while 30 indicated that they do not. Educators were asked to describe what they teach if they indicated that they do so. Of the 30 respondents who said yes, 24 described that process with 29 different comments, as some provided more than one way that the approach is addressed in the curriculum. Twelve respondents indicated that the information was embedded in methods courses, two within percussion courses, four addressed it through improvisational experiences, one had an Introduction to Orff Schulwerk course, one a specific Orff-based music therapy course, and two respondents required Level I Orff Schulwerk teacher training that was part of their curriculum. Some were less embedded in the curriculum, as two provided reading content on the topic, three stated they use Orff instruments, while one said it was supported during clinical practicum supervision but not the academic programme. One mentioned extensive previous experience in Orff but did not indicate how it was conveyed in their current curriculum (90% reliability between content coders). See Table 2 for information about *Orff Training*.

Professional development

Eighty (30.5%) of the 262 participant respondents indicated they had attended Orff-based music therapy sessions at AMTA conferences, 15 (5.7%) had done the same at AOSA conferences, and 69 (26.3%) had attended local or state Orff workshops. Of the 262 respondents, only 8 (3.1%) indicated that they were members of AOSA. See Table 3 for information about *Professional Development.*

Only 43 of the 80 who responded that they had attended sessions at AMTA provided information about topics, some articulating more than one. Fifteen described sessions giving a general overview of Orff, 10 identified actual presenters (Colwell, Bitcon, Bang, Detmer, Kleiner, Robbins), 13 responses were related to special populations (e.g. adult bereavement and hospice, individuals with cancer, children with various developmental disabilities), while nine referenced various Orff media (e.g. instruments, body percussion, improvisation, chant writing, and children's literature) (100% reliability between content coders).

Of the 15 individuals who had attended sessions at AOSA with music therapy-related topics, eight offered topics; with five general, two specific, and one with both general and specific. For the three specific areas, one was on improvisation and grief, one language development, and one music and special learners (100% reliability between content coders). Of the 69 who indicated they attended workshops, 25 responded with one or more specific topics/presenter names including various Orff media (15), Orff Schulwerk process (4), population-focused (5), presenters (9 different individuals), and clinical applications (1) (99% reliability between content coders).

Question (total number of respondents *N*/%)	Category	*N* participants who responded to individual question	% participants who responded to individual question
Attended Orff-based music therapy sessions at AMTA conferences (262/100%)	Yes	80	30.5%
	No	**182**	**69.5%**
Attended Orff-based music therapy sessions at AOSA national conventions (262/100%)	Yes	15	5.7%
	No	**247**	**94.3%**
Attended local or state Orff workshops (262/100%)	Yes	69	26.3%
	No	**193**	**73.7%**
Member of AOSA (262/100%)	Yes	8	3.1%
	No	**254**	**96.9%**

Table 3: Professional development of survey respondents

Clinical practice

When asked if respondents used Orff-based music therapy in their clinical practice, 104 (39.7%) said yes, with each giving a response of how it was being used, along with 10 respondents who initially said no; therefore, 114 actually responded to the narrative portion. Twenty-one responded that they were not using Orff, gave vague responses ('in a way'), or provided frequency information rather than content ('occasionally'). Some respondents gave more than one description of what and/or how they were using Orff in their clinical practicum, yielding a total of 103 different responses. Forty-four statements focused on Orff media, techniques, strategies, or process, while 42 referenced the use of either Orff melodic percussion or classroom percussion instruments. Twelve talked about specific interventions or populations, three referenced facilitating Orff ensembles, and two talked about creating Orffestrations (86% reliability between content coders). As a follow-up, participants were asked to indicate what Orff media, instrumentation, and resources they use regardless of whether they answered yes to the question about Orff-based music therapy in their clinical practice. Due to the possibility of checking all or none, percentages and responses vary. Detailed information for each aspect of these three subcategories is presented in Table 4. In examining specific media, 207 respondents indicated they do use Orff media with improvisation the most common use (90.3%). When exploring instrumentation, 124 (70.9%) of the 175 who indicated they use Orff instruments selected Alto Xylophone as the instrument used most frequently. Only 128 participants indicated that they use any of the resource options listed, with 'therapist-composed' the most common option used. One hundred and twelve of the 128 (87.5%) reported creating their own orchestrations.

Treatment outcomes

All 262 participant respondents answered this question. Respondents could select one or more of the six listed domains of social, emotional, behavioural, motor, communication, and cognitive; therefore, percentages add up to more than 100%. Although there was not strong disparity among domains, 95.4% of the participants felt that Orff-based music therapy could be effective for the social domain followed closely by 92.0% of participants checking the motor domain (see Table 5).

Question (total number of respondents *N*/%)	Category	*N* participants who responded to individual question	% participants who responded to individual question
Use Orff in clinical practice (262/100%)	Yes	104	39.7%
	No	**158**	**60.3%**
Media (Yes= 207/79.0% of total N; % of those indicating Yes included)	**Improvisation**	**187**	**90.3%***
	Body Percussion	156	75.4%
	Ostinato	130	62.8%
	Chanting	120	60.0%
	Instrumental Colour	77	37.2%
	Borduns	54	26.1%
	No/Do not use media	55	21.0% of total N
Instrumentation (Yes= 175/66.8% of total N; % of those indicating Yes included)	Soprano Glockenspiel	104	59.4%*
	Alto Glockenspiel	68	26.0%
	Soprano Xylophone	89	38.9%
	Alto Xylophone	**124**	**70.9%**
	Bass Xylophone	73	41.7%
	Soprano Metallophone	55	31.4%
	Alto Metallophone	71	40.6%
	Bass Metallophone	36	20.6%
	No	87	33.2% of total N
Resources (Yes= 128/48.9% of total N; % of those indicating Yes included)	**Therapist-composed**	**112**	**87.5%***
	Precomposed/published	50	39.0%
	Borrowed from presenter	49	38.3%
	Borrowed from colleague	31	24.2%
	N/A /don't use these resources	**134**	**51.1% of total N**

*percentages revised for those only answering, yes, they use media, instrumentation or resources

Table 4: Clinical practice: Media, instrumentation, and resources

Question (total number of respondents *N*/%)	Category	*N* participants who responded to individual question	% participants who responded to individual question
Domains for which Orff-based music therapy could be effective (262/100%)	**Social**	**250**	**95.4%**
	Motor	241	92.0%
	Communication	222	84.7%
	Cognitive	219	83.6%
	Emotional	214	81.7%
	Behavioural	198	75.6%

Table 5: Treatment outcomes

Participants were then asked to give an example of an appropriate clinical intervention for the *one* domain they thought would most naturally fit Orff-based music therapy from a predetermined list of six (social, emotional, behavioural, motor, communication, and cognitive). They were asked to list the domain and give a brief example of an intervention. Of the 262 respondents, 184 chose to supply domains as requested; yet some gave more than one, for a total of 194 responses. Seventy chose social, 35 emotional, 31 communication, 24 motor, 17 cognitive, 11 behavioural, while six indicated that it could be used to address all six of the domains presented on the survey (100% reliability between content coders).

Participants were also asked to indicate three treatment outcomes that they felt could be successfully addressed based on their understanding of Orff-based music therapy. Of the 262 respondents, 246 participants gave between one and three specific treatment outcomes for an overall total of 721. Categorising these outcomes into associated domain areas, seven domains were represented with the percentage of outcomes under each domain provided: motor, (25.52%) social (20.80%), cognitive (17.75%), emotional (16.65%), communication (13.32%), behavioural (5.13%), and psychosocial (0.83%). The researcher notes the choice to add the psychosocial domain based on content of provided treatment outcomes (89% reliability between content coders).

Professional competencies

Participants were asked to select all professional competencies within Music Foundations that they felt could be addressed through training in the Orff process for student music therapists. Under *1. Music Theory and History,* 73.3% checked 1.5 Transpose simple compositions. Within *2. Composing and Arranging,* 92.7% checked 2.1 Compose songs with simple accompaniment, and 90.5% checked 2.2 Adapt, arrange, transpose and simplify […] ensembles. Almost 79% checked 3.2 Perform in small and large ensembles under *3.Major Performance Medium Skills.*

Under *Functional Music Skills (voice, piano, guitar, percussion),* 85.9% checked 4.1.8 Utilise basic percussion techniques on several standard and ethnic instruments. Also, under *Functional Music Skills,* 90.5% of the participants checked 4.3 Improvise on pitched and unpitched instruments, and vocally in a variety of settings including individual, dyad, small or large group. Under *Conducting Skills*, 76.0% of participants checked 5.2 Conduct small and large vocal and instrumental ensembles, while 82.8% checked 6.1 Direct structured and improvisatory movement experiences under *Movement Skills.* Descriptive information on each competency is presented in Table 6.

Participants were also asked to indicate which were the top three competencies that they felt would be most effectively addressed through training in Orff-based music therapy, and this information is presented in Table 7. Condensed data indicates that the top three competencies that respondents felt would be most effectively addressed through training in Orff-based music therapy are 2.2 Adapt, arrange, transpose, and simplify […] ensembles, 4.2 Develop original melodies, simple accompaniments, and short pieces extemporaneously in a variety of mood and styles, vocally and instrumentally, and 4.3 Improvise on pitched and unpitched instruments, and vocally in a variety of settings including individual, dyad, small or large group.

Question (total number of respondents *N*/%)	Category	*N* participants who responded to individual question	% participants who responded to individual question
Music theory and history (246/100%)	1.1 Recognise standard works in the literature.	86	32.8%
	1.2 Identify elemental, structural, and stylistic characteristics of music from various periods and cultures.	141	53.8%
	1.3 Sight-sing melodies of both diatonic and chromatic makeup.	175	66.8%
	1.4 Take aural dictation of melodies, rhythms, and chord progressions.	178	67.9%
	1.5 Transpose simple compositions.	**192**	**73.3%**
Compositional and arranging skills (258/100%)	**2.1 Compose songs with simple accompaniment**	**243**	**92.7%**
	2.2 Adapt, arrange, transpose, and simplify music compositions for small vocal and non-symphonic instrumental ensembles	237	90.5%
Major performance medium skills (228/100%)	3.1 Perform appropriate undergraduate repertoire; demonstrate musicianship, technical proficiency, and interpretive understanding on a principal instrument/voice.	102	38.9%
	3.2 Perform in small and large ensembles	**206**	**78.6%**
Functional music skills (voice, piano, guitar, and percussion) (257/100%)	4.1.1 Lead and accompany proficiently on instruments including, but not limited to, voice, piano, guitar, and percussion.	195	74.4%
	4.1.2 Play basic chord progressions in several major and minor keys with varied accompaniment patterns.	167	63.7%
	4.1.3 Play and sing a basic repertoire of traditional, folk, and popular songs with and without printed music.	184	70.2%
	4.1.4 Sing in tune with a pleasing quality and adequate volume both with accompaniment and acapella.	178	67.9%
	4.1.5 Sight-read simple compositions and song accompaniments	177	67.6%
	4.1.6 Harmonise and transpose simple compositions in several keys	158	60.3%
	4.1.7 Tune stringed instruments using standard and other tunings.	62	23.7%
	4.1.8 Utilise basic percussion techniques on several standard and ethnic instruments.	**225**	**85.9%**
Functional music skills (256/100%)	4.2 Develop original melodies, simple accompaniments, and short pieces extemporaneously in a variety of moods and styles, vocally and instrumentally.	230	87.8%
	4.3 Improvise on pitched and unpitched instruments, and vocally in a variety of settings including individual, dyad, small or large group.	**237**	**90.5%**
	4.4 Care for and maintain instruments.	212	80.9%
Conducting skills (230/100%)	5.1 Conduct basic patterns with technical accuracy	182	69.5%
	5.2 Conduct small and large vocal and instrumental ensembles.	**199**	**76.0%**
Movement skills (229/100%)	**6.1 Direct structured and improvisatory movement experiences.**	**217**	**82.8%**
	6.2 Move in a structured and/or improvisatory manner for expressive purposes.	204	77.9%

Table 6: AMTA professional competencies: Music foundations

Competency	Frequency
1.1	1
1.2	8
1.3	7
1.4	4
1.5	11
2.1	57
2.2	69
3.1	5
3.2	18
4.1.1	18
4.1.2	8
4.1.3	22

Competency	Frequency
4.1.4	7
4.1.5	9
4.1.6	5
4.1.7	1
4.1.8	37
4.2	80
4.3	107
4.4	6
5.1	11
5.2	34
6.1	59
6.2	27

Table 7: AMTA professional competencies respondents deemed most effectively addressed through training in Orff

DISCUSSION

The purpose of this research study was to examine the knowledge and training of Orff-based music therapy among music therapy students, clinicians, and educators using a variety of demographic, training, and outcome variables. The results section answers seven research questions posed to address the primary purpose statement.

Data summary

Demographics: As expected in our field, the majority of respondents were female, with a somewhat balanced dispersion across experience from students through to those in the profession for more than 25 years; most were MT-BCs, and 22.9% were educators. Survey respondents were from all seven AMTA regions with a small representation of international members. While the response rate was low, the diversity of respondents was evident from a review of these demographics. A total of 116 dropped out of the survey at various stages across sections. It appears a bit less than half of those that dropped out (51, 44.0%) did so at the end of demographics, just as they were asked to give a definition of Orff Schulwerk in music education and music therapy. Perhaps they felt that if they did not have that knowledge, it would not be appropriate to continue with the survey. Another large group of respondents who left the survey (48, 41.4%) did so after the section on clinical practice as they started the section on treatment outcomes. It is possible this group of respondents did not use Orff in their clinical practice or perhaps did not feel they could adequately offer suggestions on treatment options due to their lack of knowledge of or experience with Orff-based music therapy.

Definitions: Sixty-two per cent (163) of respondents provided a definition for Orff Schulwerk in music education, and 71.4% (187) provided a definition for Orff-based music therapy. Definition lengths and complexity were diverse among respondents. In running an initial word-frequency

analysis using the online tool, *Textalyzer,* of the 163 who provided definitions for Orff Schulwerk in music education, results indicated that the top seven most frequently used words were music (154), instruments (62), movement (49), Orff (46), musical (45), using (42), and learning (41). In running a comparable initial word frequency analysis of the 187 provided definitions for Orff- based music therapy, results indicated that the top seven most frequently used words were music (127), Orff (110), goals (56), instruments (55), use/using (52), musical (51), and therapy (47).

Training: The researcher discovered that 56% (146) of the respondents indicated they had experienced Orff training in their education programme, with approximately half of the educators indicating they teach Orff-based music therapy within their curriculum, yet of those who had completed an internship, only 9.3% (23) indicated training during internship. Each participant that indicated they had experienced training gave a brief description, although with varied specificity. Somewhat surprising, although encouraging to the researcher, was that 38 of the 262 (14.5%) respondents had completed at least their Level 1 AOSA Teacher Training certification.

Professional development: Approximately 31% of respondents had attended sessions related to Orff-based music therapy at AMTA, as well as approximately 32% who reported attending sessions through AOSA national conferences and local or state Orff workshops. Session topics were requested from the respondents and a content analysis of those areas was condensed by comparable topics and reported. AMTA session topics included a general overview of Orff, focus on specific populations, targeted Orff media, while some respondents named specific presenters. AOSA and local workshops topics also provided both general and specific information that focused on media, process, specific populations, outcomes and clinical applications, and strategies for working with children with exceptionalities. Again, specific presenters were named by respondents.

Clinical practice: With 56% (146) of survey respondents reporting that they received academic training in Orff, the researcher was interested in seeing how many indicated using Orff-based music therapy in their clinical practice. Approximately 40% (104) indicated that they *did* use Orff, and data on media, instrumentation, and resources is included in the results. This clinical use is supported by authors who have described working with various clinical populations (Colwell, 2005, 2009, 2012, 2016; Gadberry, 2005; Hilliard, 2007; Kaplan, 2005; Register & Hilliard, 2007). It was not surprising to the researcher that improvisation was the most prevalent media focus, partially due to its inclusion in many different music therapy approaches as well as being applicable and accessible across developmental levels and chronological ages. Recent research using the Orff process specifically supports this use of improvisation within clinical practice for outcomes such as decreased anxiety in college students (Detmer, 2014) or to impact pain, fatigue, anxiety, and mood in cancer patients (Colwell & Fiore, in press). The researcher notes the reporting of specific Orff media through the use of chanting, body percussion and ostinati. Almost 88% (112) of the respondents who reported they use Orff-based resources indicated they use therapist-composed resources, which can be expected due to the dearth of music therapy outcome-focused, pre-composed or intentionally disseminated published literature.

Treatment outcomes: All survey respondents answered the question about treatment outcome domains that they felt could be impacted effectively by implementation of Orff-based music therapy. All six presented domains received attention from the respondents; with a range of percentages, from highest (social at 95.4%) to lowest (behavioural at 75.6%). After this question on domain selection, respondents were asked for which three treatment outcomes that they felt could be most

successfully addressed based on their understanding of Orff-based music therapy. The researcher placed these outcomes under the same domains provided in the previous question. Although not one of the originally presented domains, the researcher added psychosocial-based on respondent content as they listed potential treatment outcomes. This addition of psychosocial is supported by clinically anecdotal as well as data-based literature (Colwell, 2009; Colwell et al, 2013; Colwell & Fiore, in press; Detmer, 2014; Hilliard, 2007) that targeted outcomes associated with this domain. Therefore, seven domains were now represented with percentage of outcomes under each domain provided: motor, (25.52%) social (20.80%), cognitive (17.75%), emotional (16.65%), communication (13.32%), behavioural (5.13%), and psychosocial (0.83%). It was noted by the researcher that the order of domains presented in the initial question asking respondents within which domains they felt Orff-based music therapy could be effective was different in the subsequent question that asked respondents to provide three potential treatment outcomes without self-assigning a domain to those outcomes. Despite differences in order, existing literature does support the focus on social and motor domains as the two with the highest percentage for both questions (Colwell, 2012; Gadberry, 2005; Register & Hilliard, 2008). Based on these results, in future investigation the researcher would inquire as to what the respondents felt would be the specific treatment outcomes within each domain which would be most therapeutically impacted by the Orff process.

Professional competencies: When asked to select all professional competencies within Music Foundations that they felt could be addressed through training for student music therapists, each competency was selected with specific data reported in the Results. The top three solely on the basis of frequency count were 2.1 (Composing/Arranging: compose songs with simple accompaniment), 2.2 (as above) and 4.3 (as above). The researcher was most interested in the data of the three competencies participants felt would be *most* effectively addressed through training in Orff-based music therapy. When specifically asked that question, the 'top three' were 2.2 (Composing/Arranging: adapt, arrange, transpose, and simplify songs), 4.2 (Functional Music: original melodies, simple accompaniments/ pieces created extemporaneously), and 4.3 (Functional Music: improvise). As an educator and a proponent of Orff, and conceptualising it from the perspective of student music therapist instead of client outcomes, the researcher was fascinated to see that so many respondents felt it was possible to facilitate training in Music Foundations through the Orff process. While teaching a course targeting *Orff Applications in Music Therapy*, the researcher has often been struck by the improvement in music skills of the student music therapists enrolled in the class and the potential dual-purpose served by participation in this course.

Limitations: As in every study, one must be aware of multiple limitations during development, implementation, analysis, or interpretation. In examining the survey, the researcher recognised that the gender question was not inclusive and should be revised in subsequent work. The survey itself was too long and should have been divided into more than one request for input from the profession. This length, as well as the potential misinterpretation that respondents needed a prior knowledge in Orff-based music therapy to complete the survey, may have contributed to the low number of respondents who attempted but did not complete the survey. There needed to be a better explanation when disseminating the survey that respondents did not have to have experience with Orff to complete the survey as the intention of the survey was to determine what do students, professionals and educators know/not know, use/not use, and teach/not teach related to Orff-based music therapy.

Implications for future research and training

In consideration of future research and potential training, this researcher is interested in answering the following questions:

- Is there, or should there be, a comprehensive definition of the Orff Schulwerk process and Orff-based music therapy that could be used when developing research and potential training opportunities?
- What is the Orff-based music therapy training that is being completed by educators and internship directors? Is it accurate to the Orff process or is skewed more toward the inclusion of Orff instruments and/or select components of the media as supportive elements within music-based interventions?
- Could a therapist training process be developed comparable to AOSA's teacher training levels certification? If so, what would that training process look like and how would it be imparted to the clinical and student membership of AMTA? (Colwell, in progress)
- Through a systematic, scoping, or integrative review (Colwell & Sipes, in progress), what outcomes-focused or intervention-based research (either music education or music therapy) has been published using the Orff Schulwerk process?
- Based on the knowledge obtained from these types of reviews, what is the conceptual framework that should be formulated before stages of intervention research are implemented or before a training process is created and field-tested?

As an individual with both a music education and therapy background, and with the opportunity to complete three levels of Orff Schulwerk teacher training certification and the AOSA Master Class, the researcher has become passionate about the impact of Orff-based music therapy both for the student music therapist and the diverse representation of clients we serve. From an examination of the data obtained through this survey, it appears that respondents were familiar with the Orff approach in both music education and music therapy, although there was variation in how they defined it, their level of training, and use within clinical practice. Although approximately half of the respondents had received training and half of the educators reported doing such training, a consistent definition, description of training, and reporting of clinical use showed quite a bit of diversity. This statement is not intended to be negative but, instead, factual; and this diversity may be most appropriate given the different philosophical and pedagogical approaches to music therapy training. In particular, it is important to note that an in-depth analysis of the respondent-provided definitions was not an intended outcome of this study. Providing definitions was an opportunity for the respondents to articulate their own interpretation of the Orff Schulwerk process and Orff-based music therapy to potentially contextualise their survey responses.

CONCLUSIONS

Orff-based music therapy has the potential to encompass the lifespan, and be used in one-on-one, small, or large group settings in various models (i.e. medical, educational, correctional). For those of us interested in training therapists in using Orff-based music therapy, it was imperative to examine

the profession's understanding and perception of this process as it applies to music therapy. Although limited in scope, this survey provided a foundation of information to provide a platform for future research and clinical training. The researcher recognises that there appeared to be more knowledge of, training in, and clinical use of Orff-based music therapy than originally anticipated. Definitions, while considerably diverse, had some accuracy and substance true to how the AOSA national professional organisation presents itself to its membership and the public. It appears that in examining the participants' overall survey responses, the researcher may be able to determine and create a training model and format suitable for the student music therapist as well as the practising clinician, and potentially initiate the creation of theoretical and conceptual frameworks for intervention-based research studies.

REFERENCES

Beegle, A. C., & Campbell, P. S. (2002). Teaching music to children in times of crisis. *The Orff Echo, 34*(3), 38-40.

Bessinger, M. (2005). Orff process successful in teaching students with special needs. *The Orff Echo, 38*(1), 9-10, 12.

Bitcon, C. H. (2000). *Alike and different: The clinical and educational uses of Orff-Schulwerk* (2nd ed.) Gilsum, NH: Barcelona Publishers.

Bonkrude, S. (2005). Orff Schulwerk helps uncover, express and heal emotional conflicts. *The Orff Echo, 38*(1), 11-12.

Colwell, C. M. (2005). The Orff approach to music therapy. The Orff Echo, 38(10), 19-21.

Colwell, C. M. (2009). Orff-based Music Therapy in the pediatric hospital setting. *Orff Echo, 41*, 20-23.

Colwell, C. M. (2012). Orff-based Music Therapy with students with TBI (Traumatic Brain Injury). *Orff Echo, 44*(3), 23-25.

Colwell, C. M. (2016). Children's storybooks to address speech and language challenges. *Orff Echo, 48*, 18-22.

Colwell, C. M. (in progress). *Adapting the Orff approach for music-based interventions in clinical and research settings.* Unpublished manual for therapist training.

Colwell, C. M. (2020). Orff Schulwerk and special populations: A content analysis of *The Orff Echo. The Orff Echo, 52,* 46-54.

Colwell, C. M., Achey, C., Gillmeister, G., & Woolrich, J. (2008). The Orff approach to music therapy. In A. A. Darrow (Ed), *Introduction to Methodologies in music therapy* (2nd ed., pp. 11-24). Silver Spring, MD: AMTA, Inc.

Colwell, C. M., & Edwards, R. C. (2010). The impact of training in the Orff Schulwerk process on music therapy session plans. *The Orff Echo, 42*(4), 36-40.

Colwell, C. M., Edwards, R., Hernandez, E., & Brees, K. (2013). Impact of music therapy interventions (listening, composition, Orff-based) on the physiological and psychosocial behaviors of hospitalized children: a feasibility study. *Journal of Pediatric Nursing, 28*(3), 249-257.

Colwell, C.M., & Fiore, J. (in press). Feasibility of patient-selected singing and patient-created Orff chant as music-based interventions in supportive cancer care. *Journal of Music Therapy*.

Colwell, C. M., & Sipes, A. (in progress). An integrative review of intervention-based research using the Orff process in music education and music therapy.

Dakin, J. B. (2015). The Orff angels: Adults learning through the Schulwerk. *The Orff Echo, 47*(2), 26-29.

Detmer, M. (2014). *Effect of Orff-based Music Therapy on state anxiety of music therapy majors.* Unpublished masters thesis, The University of Kansas.

Ernst, R. (2003). Orff Schulwerk for senior adults. *The Orff Echo, 35*(2), 28-31.

Furman, A. G., & Kaplan, R. S. (2011). Orff and autism: Developing reciprocal language through chant, song, and literature. *Music Therapy Today, 9*(1), 168-169.

Gadberry, A. (2005). Reaching students with special needs through the Orff approach. *The Orff Echo, 38*(1), 27-31.

Health Communications Unit at the Centre for Health Promotion. (1999). *Conducting survey research.* Toronto, Ontario: University of Toronto. Retrieved at http://gradnyc.com/wp-content/uploads/2012/08/GNYC_Academy_Workshop-3_Conducting-Survey-Research.pdf

Hilliard, R.E. (2007). The effects of Orff-based Music Therapy and social work groups on childhood grief symptoms and behaviors. *Journal of Music Therapy, 44*(2), 123-138.

Kaplan, R. (2005). Adaptation, the fifth component of the Schulwerk. *The Orff Echo, 38*(1), 13-16.

Lewis, K. (2015). Serving English language learners in the Orff Schulwerk classroom. *The Orff Echo, 47*(2), 14-17.

Maltas, C. J., & Pappas, J. (2005). Older adults respond to the Orff approach. *The Orff Echo, 38*(1), 17-18.

McCord, K. (2012). The instrumentarium and children with disabilities. *The Orff Echo, 44*(3*), 19-22.*

McCord, K., & Rogers, L. (2010). Students with disabilities making music. *The Orff Echo, 42*(4), 29-31.

Miller, C. (2013). Teaching students with disabilities: A heart of acceptance. *The Orff Echo, 45*(3), 22-25.

More on Orff Schulwerk. (2019, December 15). Retrieved from http://aosa.org/about/more-on-orff-schulwerk/

Opelt, A. (2015). The Orff-Schulwerk: A method for adults? *The Orff Echo, 47*(4), 30-33.

Orff, G. (1989). *Key concepts in the Orff music therapy*. (J. Day & S. Salmon, Trans.) London: Schott & Co. Ltd.

Perlmutter, A. (2016). Using Orff Schulwerk to engage students with disabilities. *Teaching Music, 23*(4), 48.

Register, D.M., & Hilliard, R.E. (2008). Using Orff-based techniques in children's bereavement groups: A cognitive-behavioral music therapy approach. *The Arts in Psychotherapy, 35,* 162-170.

Richardson, M. L. (2003). An Orff program for adults. *The Orff Echo, 35*(2), 32-33.

Richardson. M. L. (2008). Swing ensemble for pitched percussion: A new paradigm for Orff Schulwerk with senior adults. *The Orff Echo, 40*(2), 9-13.
Sabourin, D. (2000). Sharing in process: Orff Schulwerk in intergenerational settings. *The Orff Echo, 32*(2), 32-34.
Sain, L., Thaxton, D., & Gallo, D. (2013). Orff Schulwerk and the inclusive classroom. *The Orff Echo, 45*(3), 10.
Salmon, S. (2013). Listening, feeling, playing: Music and movement for children with hearing loss. *The Orff Echo, 45*(3), 29-33.
Siebenaler, D. (2014). The effect of the Orff approach on behaviors of two students with attention deficit disorder: A case study. *The Orff Echo, 46*(4), 50-56.
Shain, E. (2011). *Feasibility of Orff-based Music Therapy on the identification and development of coping strategies in children with psychiatric issues: Case studies* (Order No. 1494630). Available from Dissertations & Theses @ University of Kansas; ProQuest Dissertations & Theses Global. (874961411). Retrieved from https://search-proquest-com.www2.lib.ku.edu/docview/874961411?accountid=14556
Shotwell, R. (1985). Inter-generational programs. *The Orff Echo, 18*(1), 25.
Thomforde, V. (2018). Adaptive solutions: Recorder instruction for students with physical differences. *The Orff Echo*, *51*(1), 16-21.
Voigt, M. (2003). Orff Music Therapy-An overview. *Voices: A Word Forum for Music Therapy.* Retrieved October 19, 2004, from http://www.voices.no/mainissues/mi40003000129.html
Voigt, M. (2013). Orff music therapy: History, principles and further development. *Approaches: Music Therapy & Special Music Education, Special Issue 5*(2), 97-105. Retrieved from http://approaches.gr/special-issue-5-2-2013
Whitley, R. (2013). The Orff process in the ESL classroom: Teaching suprasegmental pronunciation. *The Orff Echo, 45*(3), 26-28.

Ελληνική περίληψη | Greek abstract

Γνώση και κατάρτιση στη μουσικοθεραπεία Orff μεταξύ φοιτητών, θεραπευτών και καθηγητών

Cynthia M. Colwell

ΠΕΡΙΛΗΨΗ

Σκοπός αυτής της ερευνητικής μελέτης ήταν η διερεύνηση της γνώσης και της κατάρτισης στη μουσικοθεραπεία που βασίζεται στις αρχές του συστήματος Orff μεταξύ των φοιτητών, των θεραπευτών και των καθηγητών, εστιάζοντας σε ένα εύρος δημογραφικών, εκπαιδευτικών και μετρήσιμων εκ του αποτελέσματος μεταβλητών. Ένα ηλεκτρονικό ερωτηματολόγιο αποτέλεσε το εργαλείο αξιολόγησης σχεδιασμένο για την επίτευξη αυτού του σκοπού και επτά συναφών ερευνητικών ερωτημάτων εστιάζοντας στα εξής: (1) δημογραφικά στοιχεία, (2) ορισμοί, (3) εκπαίδευση, (4) επαγγελματική ανάπτυξη, (5) κλινική πράξη, (6) θεραπευτικά αποτελέσματα, και (7) επαγγελματικές ικανότητες. Βασικά περιγραφικά στατιστικά στοιχεία προέκυψαν από το SurveyMonkey, ενώ η ερευνήτρια συνόψισε το παρεχόμενο υλικό αφηγηματικού περιεχομένου σε συντομευμένες ανταποκρίσεις. Η παρουσίαση των συμπερασμάτων και της συζήτησης είναι οργανωμένη σύμφωνα με αυτά τα επτά ερευνητικά ερωτήματα, και συμπεριλαμβάνονται στοιχεία σχετικά με τις επιπτώσεις στην εκπαίδευση και τις μελλοντικές έρευνες. Συνοψίζοντας μόνο κάποια σχετικά αποτελέσματα, το 56% των 262 συνολικά ερωτηθέντων ανέφερε ότι έχει εκπαιδευτεί στη μουσικοθεραπεία που είναι βασισμένη στο σύστημα Orff κατά τη διάρκεια των ακαδημαϊκών τους σπουδών. Εκατό τέσσερις ερωτηθέντες (το 39,7% των 262) ανέφεραν ότι χρησιμοποιούν αυτήν την προσέγγιση στην κλινική τους πράξη και το 95,4% θεωρεί ότι θα μπορούσε να είναι αποτελεσματική στον κοινωνικό τομέα. Οι συμμετέχοντες σημείωσαν ότι οι παρακάτω επαγγελματικές ικανότητες θα μπορούσαν να καλυφθούν μέσω της εκπαίδευσης των φοιτητών μουσικοθεραπείας στη διαδικασία του συστήματος Orff: η τονική μεταφορά απλών συνθέσεων, η σύνθεση τραγουδιών με απλή αρμονική συνοδεία, η προσαρμογή, η διασκευή, η μετατροπία και η απλοποίηση μουσικών έργων για μικρά φωνητικά και μη-συμφωνικά ορχηστρικά σύνολα, η χρήση βασικών τεχνικών κρουστών σε ποικίλα καθιερωμένα και παραδοσιακά κρουστά όργανα, καθώς και ο αυτοσχεδιασμός σε μελωδικά και μη-μελωδικά όργανα, αλλά και με τη φωνή σε διάφορα πλαίσια συμπεριλαμβανομένων το ατομικό τραγούδι, ντουέτο, μικρό ή και μεγάλο φωνητικό σύνολο.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

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ARTICLE

Relaxation Music (RM), Mindfulness Meditation (MM) and Relaxation Techniques (RTs) in healthcare: A qualitative case study of practices in the UK and South Korea

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ABSTRACT

Relaxation Music (RM), Mindfulness Meditation (MM) and Relaxation Techniques (RTs) are widely used in healthcare contexts and these interventions have been investigated for integrated healthcare, psychotherapy treatment and collaborative and multidisciplinary approaches. However, the information exchange between healthcare practitioners in the UK and South Korea has so far been limited and cross-cultural comparisons of RM, MM and RTs within the healthcare context of the UK and Korea have previously been unexplored. The aim of this paper is to present a summary of the key aspects from an unpublished PhD study (Hwang, 2018). The focus of this paper is to explore the similarities and differences in understanding the use of RM, MM and RTs between practitioners in the UK and Korea. A qualitative case study methodology was used and data were collected through semi-structured interviews with six Korean and six UK healthcare practitioners in three professional areas: medical practice, meditation, and music therapy. Similarities (in outlooks and purposes, methods, interests and concerns, responses and approaches) and differences (in historical and traditional influences, behavioural patterns and particular emphases) were identified. The value of cross-cultural and multidisciplinary research is increasingly recognised and the use of RM, MM and RTs as mind-body-spirit interventions are considered to be useful integrated treatments. This paper contributes to cross-cultural qualitative research between South Korea and the UK and integrating theory and practice with respect to RM, MM and RTs.

KEYWORDS

relaxation music,
mindfulness meditation,
relaxation techniques,
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INTRODUCTION

The use of Relaxation Music (RM), Mindfulness Meditation (MM) and Relaxation Techniques (RTs) has been stimulated by the growing interest in the interactions between mind and body and these interventions are considered to be useful in psycho-physiological therapeutic processes (Davidson et al., 2003; Edwards, 2016; Hanh, 2008). In both East and West, MM, RTs and music have been demonstrated to be beneficial therapeutic mediators within health, education and social community settings (Crane & Kuyken, 2013; Grocke & Wigram, 2006; Kabat-Zinn, 2009). Existing evidence supports the effectiveness of music-assisted relaxation including listening to music, deep diaphragmatic breathing, progressive relaxation technique, imagery and breathing techniques (Bonny, 2001; Robb, 2000; Thaut & Davis, 1993; Wolfe et al., 2002).

There is an emerging evidence base to suggest that, under certain conditions at least, RM, MM and RTs can be of benefit to clients such as those dealing with anger management, stress management, depression, and anxiety, as well as cancer and hospice patients (Carlson et al., 2004; Dhungel et al., 2008; Hanser, 2014; Kavak et al., 2016; Smith, 2008). In both East and West, RM, MM and RTs have been used within an integrated treatment approach. Research has indicated that such an approach can help manage stress, promote well-being and self-care (Lesiuk, 2016; Liu et al., 2019). The effectiveness of techniques relating to RM, MM and RTs have been critically reviewed (Arias et al., 2006; Krisanaprakornkit et al., 2006) and diverse health benefits reported, such as reduced psychological distress, reductions in stress symptoms and negative emotions, maintaining positive feelings, emotion regulation, increased sense of spirituality and self-actualisation (Davidson et al., 2003; Edwards, 2016; Jacobs, 2001; Smith, 2008).

Throughout history music has been used as a healing force in both Eastern and Western cultures in their own way (Choi et al., 2008; Ruud, 2008). The use of music for health is increasing within the healthcare profession, including medical practitioners interested in the combination of music and medicine (Bernatzky et al., 2011; Bunt & Stige, 2014; Nilsson, 2003). Nilsson (2003) investigated the effects of music in surgical care through a systematic review. She found that music interventions had positive effects on reducing patients' anxiety and pain. Nilsson emphasised the inexpensive nature of music interventions and potential ability of music to reduce distress. Similarly, Evans (2002) conducted a systematic review in order to investigate the effectiveness of music interventions for hospital patients. This review concluded that the use of music is recommended as supporting treatment during normal care delivery.

RM, MM and RTs have been investigated in fields such as: music in health, music therapy, psychotherapy, complementary and alternative therapies, advanced nursing, mental health, hospice and palliative medicine (Dobkin, 2008; Klainin-Yobas et al., 2015; Kwekkeboom et al., 2010). Cochrane reviews testified the increasingly widespread use of music in health and show evidence of the benefits of music (Bradt et al., 2013; Kamioka et al., 2014). Bradt et al. (2013), for example, examined the efficacy of music interventions, particularly listening to music, on psychological and physiological responses of coronary heart disease patients. 26 trials with a total of 1369 participants

were included. In this study it was concluded that listening to music has a moderate effect in terms of both anxiety and pain reduction.

Research shows that music can be useful in nursing activities and there is a gradual recognition of the benefits of a systematic use of music in the production of relaxation responses as well as positive changes regarding patients' emotional and physical states and distress levels (Guzzetta, 1991). In the hospital environment, music can be used simply for relaxation or recreational purposes. Further, the use of music in clinical situations, following a specific systematic approach has distinctive health benefits (Guzzetta, 2000). The systematic therapeutic process of music therapy from assessment, treatment planning, therapeutic intervention, through to evaluation of each client can be used with particular therapeutic aims in medical settings in order to achieve better outcomes for individual patients. For example, Marconato et al. (2001) investigated the effects of receptive music therapy for cardiology patients. They reported that music did not cure effectively by itself, but when music was applied in a systematic professional way, there were significant therapeutic impacts.

The use of RTs (including meditational practices) has been developed in healthcare settings and benefits of RTs in health have been reported. Meditation has now become "one of the most enduring, widespread and researched of all psychotherapeutic methods" (Walsh & Shapiro, 2006, p. 227). In the area of mental health, various self-regulation interventions using RTs have been explored to treat mental disorders, emotional disorders, conduct disorder, hyperactivity, and Social, Emotional and Behavioural Difficulties (Gootjes et al., 2011; Mowat, 2010). RTs and meditation have also been used for stress reduction and as emotional support interventions dealing with negative emotions (Jorm & Wright, 2007; McNamara, 2000). Hence RTs can support clinical treatments as well as helping to relieve and manage emotional difficulties. Arias et al. (2006) systematically reviewed the treatment of illnesses through meditative techniques, covering 82 journal articles and 958 participants. The evidence of the effect of meditation on anxiety, depression, fears and mood disorder, menopausal symptoms, as well as on learning difficulties, was a constant theme in the literature (Beauchemin et al., 2008; Chen et al., 2012; Davidson,1976; Davidson et al., 2003; Lee et at., 2016; Toneatto & Nguyen, 2007).

Meditative practices are an ongoing subject of discussion among both Eastern and Western researchers (Hofmann et al., 2010; Weick & Putnam, 2006). Western healthcare practitioners and researchers have taken an interest in meditation techniques as self-regulation strategies and for clinical applications out of a desire to develop non-pharmacological solutions and non-drug treatments (Shapiro & Giber, 1978). They were impressed with the psychotherapeutic effects and benefits of RTs and meditative practice for stress-related illness, positive mental health and relaxation responses (Shapiro & Zifferblatt, 1976). In music therapy, RTs are sometimes associated with the induction stages of GIM (Guided Imagery and Music) or MI (Music Imagery). GIM is often used and is popular as a music-assisted therapy in South Korea and now increasingly recognised and developing as such in the UK. It frequently combines RTs, although other kinds of inductions are used, for example to energise the body before the listening part of the session. Besides GIM, a wide range of methods involving RTs have been used as therapeutic tools showing that a range of receptive approaches can work at different levels (Goldberg, 2013; Grocke & Wigram, 2006; Summer, 2011).

A variety of RTs have been recognised as achieving a relaxation response, for example, progressive relaxation technique, guided relaxation imagery, breathing techniques, mindfulness, Zen meditation, walking meditation, compassionate/loving-kindness/forgiving meditation, positive psychology technique (emotional freedom technique), autogenic training, meditative prayer, yoga and transcendental meditation (Chiesa & Serretti, 2009; Jorm & Wright, 2007; Mitchell, 2009; Robb et al., 1995; Thaut & Davis, 1993; Williams & Carey, 2003; Wilson, 2014).

There is a growing recognition of mindfulness-based practice, which is actively promoted in community settings and clinical practice (Greenland, 2015; Kim, 2004; Speca et al., 2000; Williams, 2008). Studies on mindfulness-based interventions published in the UK databases report that MM has general mental and physical health benefits including stress management (e.g., National Health Service (NHS) Evidence in Health and Social Care, NHS Healthcare databases advanced search (HDAS)). The National Institute for Clinical Excellence (NICE) and National Health Service (NHS) both regarded MM as evidence-based treatment and recommend mindfulness courses for patients living with various conditions.

MM is intentional mental practice, staying in the present moment and is performed without any judgmental attitudes. The technical Buddhist term for mindfulness (sati, 念), (念 in Chinese)' is comprised of two aspects, 'mind (心)' and 'in the present moment (今)' and originating from the Sanskrit for 'remembering'. MM is originally based on Buddhist meditative practice (Kabat-Zinn et al., 1985). Kabat-Zinn wrote that "[the] contribution of the Buddhist traditions has been in part to emphasize simple and effective ways to cultivate and refine this [mindfulness] capacity and bring it to all aspects of life" (Kabat-Zinn, 2003, p.146). However, he used 'mindfulness' as '(pure) awareness' regardless of religion roots or ideology.

Meditation has been practiced for more than 2500 years and there has been a long history of introducing the meditation/Zen practice to the western culture (Coleman, 2002; Weaver et al., 2008; West, 1979). For example, Suzuki (鈴木 俊隆, Shunryū Suzuki, 1904-1971) introduced Zen philosophy to the West and many educated Westerners began to recognise Zen Buddhism and mindfulness (念) concepts around 1950 (Suzuki, 1973). Mindfulness-based meditation became popularised into mainstream Western culture by Zen masters and meditation practitioners such as Thich Nhat Hanh and Kabat-Zinn (Hanh, 2008; Kang et al., 2009; Williams, 2008).

The research of Kabat-Zinn (2009) and Williams (2008) revealed that MBSR (Mindfulness-based stress reduction) can reduce anxiety, depression and change negative emotions to positive ones. Mindfulness has been found to be a wide-ranging and effective treatment, for example for cancer patients, sleep disturbances, improving health-related quality of life and the ability to concentrate in class (Krusche et al., 2012; Vøllestad et al., 2011; Winbush et al., 2007). MM is a well-known form of meditation and known by Korean practitioners as well as many Western practitioners to have scientific backing (Kabat-Zinn, 2009; Kang et al., 2009). MM is now being offered in a wide range of formats including workshops, short courses, eight-week intensive courses, meditation retreats, and online apps and webinars. One of the reasons why the MBSR programme has successfully been adapted in Western medicine is the fact that the standardised programme and systematic guidance make it easy for practitioners to follow and use.

In Korea, MM related to Zen meditation, is one of the fundamental traditional forms of meditation. Because of the long history and cultural influence of Buddhism, meditation has long

been studied and commonly recognised as part of Korean culture and meditative practices naturally utilised in the health context (Buswell, 1993; Pihl, 1995). In the UK, MM is increasingly used for health and well-being purposes, despite there not being a historic or religious tradition. In Korea, the use of meditation for health has evolved gradually over a long time, while in the UK it has developed more rapidly during a single decade. Nevertheless, today there is considerable public and academic interest in MM in healthcare both in Korea and the UK.

This literature review explored the ways in which RM, MM and RTs have been adapted for use in evidence-based practice and their therapeutic value and benefits; it outlined the rational use of RM, MM and RTs for health and well-being. This exploration of the literature will inform the discussion as to how RM, MM and RTs are applied, and will also give insights into the different cultural assumptions that underpin these practices. This literature review highlights the absence of discussion as to actual differences in practitioners' understanding or practice in Korea and the UK, which will be the focus of this paper.

METHOD

A qualitative case study methodology was used in this study and data were collected from the three sample groups, within the UK and Korea, of music therapists, medical practitioners and meditation experts. The context of health practitioners in the UK and Korea acts as the 'cases' in this study, and therefore the methodology aims at a comparative approach to case study methodology (Yin, 2003). This study used in-depth semi-structured qualitative interviews as the method. Preliminary findings from the pre-interview process were followed up by individual face-to-face in-depth interviews and the recordings of the interviews were transcribed in full. The general focus of the research was to explore the ways in which professionals understand and use specific kinds of interventions and thereby to seek to uncover cultural differences that might lie behind their thinking and choices.

The study was carried out in line with the ethics guidelines of the University of the West of England (UWE Bristol) and was approved by the Faculty Ethics Committee.

Fieldwork and interviews

Prior to the in-depth interviews, several steps were followed: (a) Arranging informal and internal practice interviews and supervisions with mentors and supervisors; (b) Preparing an acceptable consent form; (c) Preparing a detailed information sheet to send to interviewees and topic guide; (d) Arranging and conducting two informal practice interviews; (e) Feedback from the informal practice interviews to learn more about interview approaches, skills and types of questions which was discussed with the supervision team; (f) Submitting the ethics application to the University's Faculty Ethics Committee; (g) Sending invitations (pre-interview letter containing information sheet) to 12 interviewees explaining the aims of the research; (h) Fieldwork in South Korea and the UK following approved consent; and (i) Sending additional questions after the interview (where applicable). Before invitations were sent out contact was made with suitable participants so as to assess whether participants would be available for in-depth interviews. The invitation letter then explained the nature of the research study and invited participation in the project as well as providing an information sheet about the project.

Sampling, group size and participants' information

In order to achieve a basis for comparative analysis of participants' understanding and use of RM, MM and RTs in the UK and Korea, the main participants in the study were purposively sampled according to the three population groups across both countries - those professionally engaged in medical practice; in meditation; and in music therapy. The proposed number of subjects was 12, six from each country. Below are details of all the Korean and UK interviewees' professional areas: (a) Music therapists working in university and various settings (hospice, community, school) (n = 5); (b) Medical practitioners with an interest in MM, RTs and music in healthcare (n = 4); and (c) Meditation experts working in university and community settings (n = 3). All participants were professional experts from their respective three areas with a depth of understanding of RM, MM, other forms of meditation or RTs. The 12 participants were contacted by email or phone and asked whether they would be available for face-to-face in-depth interviews.

Participants interested in RM, MM and RTs were selected, with 7-25 years of work experience in teaching or healthcare in various settings. Of the 12 interviewees, six were university professors or senior lecturers, seven were therapists, eight routinely teach RTs or meditation or music therapy in university and community settings, eight were female and four were male. All participants were anonymised and had their names changed.

Data collection

Data were collected through an audio-taped interview with each of the 12 participants. The semi-structured interviews consisted of both direct and indirect questions and ranged from 70 to 90 minutes in length. The flexibility in semi-structured interviews allowed for exploration of new ideas, topics and points of cultural comparison. (Horton et al., 2004; Radnor, 1994). Initial interview topics were: (a) Personal background/experiences; (b) Personal understanding/ attitudes about RM, MM and RTs; (c) Current practice and constraints; (d) Combining and integrating RM, MM and RTs within healthcare; (e) Cultural considerations; and (f) Recommendations and advice.

Data analysis

Qualitative data were analysed using the thematic analysis approach devised by Braun and Clarke (2006). This enabled provision of a theoretical framework for qualitative analysis of in-depth interview data through the following six stages: (a) Familiarisation; (b) Coding; (c) Searching for themes among codes; (d) Reviewing themes; (e) Defining and naming themes; and (f) Producing the final report. Following the process, potential codes were identified, generating initial codes and, through organisation of these, potential broad themes and patterns were identified. Finally, the following selected main themes were defined and named: (a) Music and health; (b) RTs and MM and health; (c) RM, MM and RTs applications and responses; and (d) Cultural context (see Table 1). Hand-coding of the analysis of interview data was carried out rather than through using a software system. Data analysis by NVivo was tried, but there were times when important details of the interview data were lost or could not be found.

Main themes	Sub-themes
Music and health	• Music and music therapy approaches (e.g., criteria for choice of music, music genre and instruments) • Music, health and well-being (e.g., personal motivations, use of music in health contexts) • Qualities and abilities of the practitioners (e.g., level of competency and abilities of the practitioners)
RTs and MM and health	• RTs and MM approaches (e.g., purposes, types and adaptations of RTs and MM, personal motivations in using RTs and MM) • RTs and MM as healthcare interventions (e.g., understanding of RTs and MM for health and well-being) • Use of RTs and meditation in health contexts (e.g., MM, breathing techniques, imagery and visualisation, mandalas)
RM, MM and RTs applications and responses	• RM, MM and RTs, creativity and spirituality • RM, MM and RTs as stress management (e.g., practitioners and trainees) • Use of RM, MM and RTs for stress management, active and receptive methods for stress management • Practitioners' understanding of relaxation and relaxation responses • Stress responses and relaxation responses/responses to RM, MM and RTs
Cultural context	• Cultural factors/understanding and use of interventions (e.g., cultural factors, cultural background and responses to interventions, religious influence, cultural factors and sound instruments) • Similarities and Differences (e.g., similarities and differences between the UK and Korea, differing familiarity with the use of interventions, similarities and differences between the three groups of participants across the countries)

Table 1: Emergent themes and sub-themes

RESULTS

In the healthcare services of Korea and the UK, the practice of RM, MM and RTs have developed into their own unique approaches. By exploring the main themes and sub-themes, we have identified similarities and differences in perceptions, understanding and outlooks with regard to the use of RM, MM and RTs between Korea and the UK.

Similarities in practice between Korea and the UK

In both countries there are basic common underlying principles behind the understanding and use of RM, MM and RTs and similar types of practices were often used. Practitioners revealed their enthusiasm for RM, MM or RTs because of perceived health benefits; these practical benefits motivate and inspire them to continue and develop their use of RM, MM and RTs. The following similarities between Korean and UK practitioners were identified (see Table 2).

Common topics	Similarities between South Korea and the UK
A common awareness (of)	The health benefits of RM, MM and RTs The value of evidence-based practice (EBP) in clinical settings The benefits of integrated health, knowledge-sharing and collaborative work
Common themes and concerns among practitioners	Client-centeredness (how to cater for and adapt to the individual) Practitioners' qualities, qualifications and level of competency Factors regarding location and environment of practice settings Relevant hospital support services and levels of funding
Common purposes in using RM, MM and RTs	As a stress management strategy As an emotion management strategy As part of a rehabilitation programme As a pain management strategy As a personal transformation tool As a component of a spiritual development programme In activities for creativity In an integrated approach to health
Common interests among practitioners	Mind-body-spirit interventions Integrative health A personal and professional interest in RM, MM and RTs Expanding the practical resources for clients' mental, physical, emotional and spiritual care Maximising health benefit outcomes

Table 2: Similarities in practice between South Korea and the UK

Similarities in stress responses and relaxation responses

RM, MM and RTs can bring about a state of mental and physical rest and tranquillity. Participants from both countries use various approaches to RM, MM and RTs in order to elicit a relaxation response and similar relaxation responses and stress responses were described (see Table 3).

Responses	Reactions to RM, MM and RTs
Stress responses	Frustrated, nervous, depressed, unrelaxed, angry, upset, sad, fearful (having phobias), experiencing discomfort
Relaxation responses to MM, RTs	Peaceful, relaxed, happy, safe, confident, dreamy or awake, hopeful, comfortable, safe, experiencing love, kindness, inner strength, a healthy mind, freedom, trust or reassurance
Relaxation responses and reactions to music	Pleasant, relaxing, beautiful, feeling of lightness, stress reduction, feeling of change in the body sensation

Table 3: Stress responses, relaxation responses and reactions to the music

Similarities in types and approaches with respect to RM, MM and RTs between Korea and the UK

From the data analysis, it was possible to identify some common features across the three interventions: RM, MM and RTs (see Table 4). Additionally, further analysis indicated more active and more receptive activities and approaches within the three interventions (see Table 5).

	Similar types and approaches
RM	Listening to recorded music, listening to music through live performance or improvisation, singing, instrument playing, music and imagery, music and drawing (e.g., mandala, creating a drawing of the imagery experience), guided imagery and music (GIM), music imagery (MI), active involvement in music improvisation by means of playing instruments, stress-releasing rhythm-based music, music composition
MM	Mindful breathing, mindfulness movement (e.g., walking meditation), guided sitting meditation, lying down meditations, body scan, loving-kindness meditation, forgiving meditation, observing-thought meditation, mindfulness meditation for everyday life (e.g., mindful eating meditation)
RTs	Progressive relaxation technique, body scan, guided imagery, visualisation, guided meditation, yoga, breathing techniques (e.g., abdominal breathing, diaphragm-breathing exercises, breath-holding tech niques, alternate nostril breathing technique), autogenic therapy, Tai-Chi, mandalas

Table 4: Similar types/approaches of RM, MM and RTs

	Active activities and approaches	Receptive activities and approaches
Approaches of RM	Active involvement in music improvisation Stress-releasing rhythm-based music Music composition Music with movement and dance Singing Instrument playing	Listening to recorded music Listening to music through live Performance or improvisation Guided Imagery and Music (GIM) Music imagery (MI) Music and drawing (e.g., mandala, creating a drawing of the imagery experience)
Approaches of MM	Walking meditation Mindful movements Mindfulness meditation for everyday life (e.g., mindful eating meditation, mindful driving meditation)	Sitting meditation Mindful breathing techniques Guided mindful meditation Body scan Mindfulness guided imagery Zen meditation Meditative prayer Loving-kindness/Forgiving meditation
Approaches of RTs	Stretching, Physical exercise Yoga Tai Chi	Breathing techniques Progressive muscle relaxation Autogenic training Visualisation techniques Mandala

Table 5: Active and receptive activities and approaches

However, the categories of active and receptive approaches might also be distinguished according to how deeply the mind and body goes into a state of relaxation. For example, while listening to music, people can actively engage in exploring the self-image and spiritual aspects of themselves and through such musical experience they may reach a deep level of inner reflection and relaxation. Similarly, sitting meditation may appear to be a passive pursuit but it can actually actively engage participants in profound mindfulness, calmness and a process of self-reflection.

Therefore, if the state of relaxation is deep, this can be regarded as an active state of relaxation and depending on the degree of relaxation and level of engagement of the relaxation response, the meaning of receptive and active can be defined in a different way. However, generally, it would be taken for granted that walking meditation or drumming is an active form whereas sitting still or listening is passive and receptive. Depending on the practitioner's own interpretation or outlook, active and receptive RM, MM and RTs can be defined in different ways. Thus, the categorisation of specific practices into active or receptive, may not be a fixed one since the same activities can be performed both actively and receptively. This leaves open to doubt the validity of the distinction between active and receptive.

Differences in emphasis in practice between Korea and the UK

Differences were seen regarding perspectives, value systems and beliefs, tendencies, preferences, resistances and approaches in the use of RM, MM and RTs. Firstly, the concept of creativity was more referred to and discussed among UK practitioners:

> Music serves two purposes. It serves the purpose of keeping it calm and quiet, but also because we believe that music taps into the creative side of the brain. [UK]

> If I use it (music) in the creative sessions, it seems to allow that feeling of allowing their minds to open up, to be creative and when I do relaxation techniques with students, I will use music. [UK]

Secondly, in Korea emphases in schooling (for young people) and the role and use of music or meditation in relation to education were more often mentioned. By contrast, UK practitioners placed more emphasis on stress in general and the use of RM, MM and RTs to achieve a state of relaxation and a positive change of mind and body for everyone, not only students:

> I focus in my therapy on how concentration can be increased when using music. Students often say music (when they like it) can help their concentration, especially during the late evening study periods in school. [Korea]

> People are so busy […] it benefits them and just helps them to take those few minutes to get rid of all the worries from their head. [UK]

Thirdly, in the UK there was greater emphasis on practicability and the use of simplified practices (e.g., the 3-minute breathing space) and grounding aspects of the practices:

> Particularly if you're using shorter, […] these can help people to feel more grounded. So, if they're feeling flooded by overwhelming feelings, negative thoughts, if you're just doing very short practices, where they're just really feeling their feet on the ground, their body on the chair, it's helping them to ground themselves into the here and now. [UK]

In Korea, by contrast, there was greater familiarity with and interest in deeper states and longer periods of meditation. The Korean participants focused more on cultivating concentration and insight-focus practices, and also theory-based practice and the theoretical framework. However, in certain settings, particularly hospital settings, simplified techniques and short grounding practice were preferred by both Korean and UK practitioners:

> Simple guided meditation, diaphragmatic breathing, body scan and autogenic training are good examples to use with patients. [Korea]

So, despite different preferences in terms of deeper or longer periods of practice, there was an underlying common understanding and recognition of the importance of adopting more practicable (often simpler) approaches for individual clients and their health needs.

Different levels of familiarity with and responses to the meditational practices and receptive approaches within the respective healthcare organisation

The use of RTs and meditation is gradually being recognised in the context of mind-body-spirit therapies, complementary medicine and integrative health both in Korea and the UK (Hubbard et al., 2015; Klainin-Yobas et al., 2015). Nevertheless, there is a difference between Korea and the UK. In other words, receptive approaches and mediational practices in the Korea are familiar, but in the UK they are still less familiar:

> Receptive techniques and achieving deep relaxation through therapy is still a relatively limited area in the UK. [UK]

By contrast, one of the South Korean interviewees said:

> We have a long tradition of meditation and a high level of interest. So, the application of relaxation techniques and meditation within healthcare will be much more straightforward. [Korea]

It seems that between the UK and Korea there were differences in resistance and acceptance regarding the use of receptive approaches and meditational practices which may be caused by different traditions, history and a sense of national feeling and character. These cultural factors and

people's way of thinking can affect people's responses, familiarities as well as participants' professional work with regard to the use of RM, MM and RTs in UK and Korean healthcare organisations.

Differences in atmosphere and preferences during MM and meditational practice

Mindfulness practice in the UK appears to be more connected to a social event in which lively group discussions can take place, while in Korea the atmosphere is more one of silence and individual practice. In the UK, during meditation sessions, participants feel free to discuss and even converse freely with other participants (relating real life stories, personal difficulties and their preferred methods of practice). These differences in atmosphere and peoples' attitudes were observed during MM, RTs and meditation practice sessions and would seem to illustrate different cultural models of practice between the UK and Korea. Participants also referred to such differences:

> Occasionally I've had people who - their intentions are very good, they want to make cups of tea to help people, […] - but they start making the tea in the middle of the relaxation. [UK]

In Korea a more formal atmosphere is preferred and conversation is considered a distraction. Rather than talking, people prefer an atmosphere of quiet or else listening to systematic guidance from the expert. In the UK a comfortable position is preferred while doing meditation, while Koreans prefer to use the more standard meditation positions, as directed by tradition or an expert:

> Sit or lie in a comfy position, spine straight but at ease, shoulders relaxed, breathe in - and - breathe out, making the out-breath slightly longer than the in-breath. [UK]

Differences between the three groups of participants from Korea and the UK

Besides the general differences between Korea and the UK a number of differences were identified among the three practitioner groups.

The music therapists' group

Music therapists use music as a primary method of treatment and the way they plan and prepare focuses to some degree on musical qualities:

> It's a lovely tool. […] A Tibetan bowl will have maybe different musical tones in it, some of which are very close together, and this causes like a low beat frequency - and because of the frequency, the brain wants to match that. And so, the brainwave has to slow down to match it. It's what I would call entrainment. [UK]

By contrast, the other two groups (medical practitioners and meditation experts) tended to use relaxation music as a background to their main work or to support their own specialisations:

> I use music as background of (my work) just to make people calm. Normally when I start just doing relaxation, we just get calm, then talk about what happened this week. [UK]

Secondly, the music therapy group paid special attention to establishing good rapport with clients and the outcome of interventions. They were therefore concerned with how to develop and maintain rapport between practitioners and clients when using RTs and RM in combination:

> Once we have developed a rapport, clients often reveal their inner emotions and tell me their real feeling. Then they seem more accepting and with this rapport volunteer more about their feelings towards the music. [Korea]

The medical practitioners' group

In this group, practicalities, such as the portability of music-playing devices, were the greatest concern when using RM, MM and RTs to support a patient's treatment and for rehabilitation in hospital. Secondly, several cautions were commonly mentioned with respect to the hospital organisation, the need for evidence-based practice and careful preparations before embarking on therapeutic treatments (in particular, checking the clients' health condition). Thirdly, this group focused more on outcomes and clear or measurable health benefits:

> In my case, I choose music which gives comfort to me and I use it as background music for my relaxation sessions for my cancer patients or heart failure patients. By using the CD player, I play the music before or during my session and I sometimes use Tibetan small bells which are good to relax them. [Korea]

> As a medical doctor, I tried to find a way that I can help patients by using relaxation skills as well as medical treatments. I started study focus on mindfulness and Herbert Benson's Relaxation Response. I think these two methods have scientific backing[...] I think that these treatments are efficacious for some patients. [Korea]

The meditation experts' group

In the use of MM and meditation, this group is more theory-focused, inclined to explore the inner self in a deep way and they value achieving deep levels of meditation in practice (personally and professionally). However, depending on the client group and situation, they also create useful and simple tools just as the other practitioner groups do and can generally be practical and happiness-focused in their orientation:

> The first approach is a theoretical study […] and the second one is a practical study based on the theoretical study. I think future research will be conducted and continued in this way [practically as well as theoretically]. [Korea]

To conclude this section, cross-cultural perceptions with regard to RM, MM and RTs among the participants have thus been identified. The client and patient groups with whom the 12 practitioners work vary in terms of their medical conditions and individual preferences; the practitioners are concerned to expand the techniques available to them. In addition, practitioners generally share a positive attitude towards collaboration work in use of RM, MM and RTs. Various similarities and differences besides the differences between the three groups and the participants as a whole were found. In a more general way, however, Korea and the UK have different cultural models of care with noted differences in perceptions and attitudes. Such differences relate particularly to different cultural and historical background, educational culture and religious outlooks. These cultural factors and their relationship to the cross-cultural perspectives under consideration will now be discussed.

DISCUSSION

Between Korea and the UK, certain differences related to cultural factors were seen in the use of RM, MM and RTs. Such different cultural factors lead to different models of healthcare and differences in outlooks and attitudes among UK and Korean practitioners. This section will discuss what cultural factors may bring about or have a bearing on the differences and similarities in relation to the use of RM, MM and RTs between the UK and Korea.

Different historical background and development of use of music (particularly in music therapy) and MM and meditational practice

Music therapy has become established as a clinical discipline in both Korea and the UK. In April 2019 there were 1080 music therapists registered with the Health and Care Professions Council in the UK (British Association for Music Therapy, personal communication, October 23, 2019) and in Korea, more than 2500 certified Korean music therapists (graduates from 23 universities) are working in various fields (The Music Education News, 2019). However, in the UK music therapy has a longer history and has developed continuously for around 60 years (British Association for Music Therapy, 2019). In Korea music therapy is a relatively young profession and discipline but has been a fast-growing university subject for about 20 years (Goodman, 2015; Kim, 2014). Music therapy is Western in its origins and the way it is used in Korea broadly follows Western practice (e.g., Guided Imagery and Music, Music and Imagery, Improvisation activities).

The way music in combination with RTs has developed and been adopted in Western music therapy has influenced the development of music therapy in Korea. Many studies have also shown evidence of how music has been combined with RTs, such as progressive muscle relaxation (Thaut, 1989), diaphragmatic breathing techniques (Wolfe et al., 2002), music assisted relaxation (Robb et al.,1995) and guided imagery (Bonny, 2001). For example, Guided imagery is one of the types of RTs often used in Korea. Bonny says through music, people can experience new consciousness which is

an altered state of consciousness (the contemporary term being non-ordinary states of consciousness) and for this process, RTs can be helpful (Summer, 2002, 2015) (see above for reference to other more energising forms of induction). While listening to the music and creating imagery, the client can reach a deeply relaxed state in the 'here and now' and this can possibly expand our consciousness and lead to self-discovery. Through this process, the client can experience self-transformation. Bonny lists a number of RTs such as progressive relaxation technique, biofeedback, Zen meditation, music-chant, transcendental meditation and mind control (Bonny & Savary, 1990; Bonny, 2001). In this sense principles, values and approaches in use of RTs and music are shared in many ways, therefore in this study several similarities in practice (e.g., common purposes, theme, concerns, interest) were discussed. But nevertheless, cultural differences can be identified, such as the respective preferences and different emphases in practice in the UK and Korea.

On the other hand, meditation and mindfulness practice are Eastern in their origins and more cultural differences can be seen which may be connected with the differing traditions, even though they share basic common underlying principles and Meditation also exists in Western cultures such as Christian contemplative prayer (Paul & Ian, 2010). In the UK, mindfulness has recently attracted a large amount of publicity and the national media has shown a particularly strong interest in MM (BBC News, 2016, 2018). Following on from the public interest, a number of universities in the UK have started up degree courses in MM (Masters degrees (Mindfulness), 2016). Mindfulness (sati, 念) originates from Buddhist traditions such as Zen Buddhism (禪佛教) (Janesick, 2016; Speca et al., 2000). In South Korea, Zen meditation has been developed in the academic world, notably by Dongguk University (東國大學校) – where the University Kabat-Zinn's Zen master Seung Sahn(崇山) studied – and has been the subject of theoretical research; whereas in UK, MM and meditation have grown in public interest and have been adapted for general health purposes in the UK and out of this there has been interest among academics (Kang et al., 2009; Williams, 2008).

In the West, mindfulness is defined as "the practice of maintaining a non-judgmental state of heightened or complete awareness of one's thoughts, emotions, or experiences on a moment-to-moment basis" (Mindfulness, 2018). Many people use it for the more practical and general mental and physical health benefits such as stress management. Therefore, historical background and understanding of meditation has given rise to actual differences in practice between the UK and Korea participants, including different levels of emphasis regarding theory-based approaches versus more practical considerations, different degrees of familiarity with receptive approaches and differing levels of resistance and acceptance when integrating RTs and MM within practice.

Differences regarding attitudes towards the integration of meditational practices

There has been an increasing acceptance of the place and value of meditational practices within healthcare both within the UK and Korea (Williams, 2008). In Korea the health benefits of meditation have been widely recognised and its place within organised healthcare has gradually developed over

time (Kim, 2004); in the UK the trend has been more recent. However, within the healthcare systems of both countries we can identify a certain inbuilt resistance to meditational practices, but for different reasons. Buddhism in Korea dates back to the 4th century AD and became the recognised national religion. Many people associate meditational practice with Buddhist practice (Seth, 2010). As was evident in the interview process, the therapy sessions with some Christians in Korea, resulted in the use of meditation being regarded as a religious resource rather than spiritual practice. This can create potential resistance and can be particularly difficult then to develop a rapport with the client at an early stage. In the UK, such issues are much less likely to occur than in Korea, and Christians or people from other faiths would be less likely to associate breathing techniques and meditation with any particular religious practice.

In the UK, meditational practice tends to be seen in terms of its health benefits, as a self-development tool or for spiritual practice, but not necessarily bound up with religion. However, since meditation is still not as popular in the UK, it is possible that there is some association with people who hold certain sets of values or beliefs. Although the NHS now recognises MM and it is becoming more mainstream and even encouraged (Marx et al., 2015), in the public mind it is far from being mainstream and may be considered something of a luxury or a fringe interest in the UK (even amongst therapists). Consequently, the reasons for acceptance and for resistance to meditational practice within healthcare may be different between the two countries. In future this situation is likely to change. Within the UK, MM is becoming much more familiar and recognised; in Korea opposition to it among the younger generation of Christians is less. Some Christian churches in Korea have even introduced meditation classes (Suh, 2012). There is an increasing focus on health benefits rather than its place in religion. The value of holistic treatment and mind-body interventions, and as such of MM, are increasingly being recognised in both countries. Therefore, we may expect there to be a change in attitudes towards the integration of meditational practices in healthcare services.

Differences in purpose and use of RTs, meditation and music

Cultural considerations may inform our understanding of RM, MM and RTs and their development in East and West. In both the UK and Korea, a great many studies have demonstrated RTs, meditation and music to be valuable therapeutic mediators in healthcare, education and social community settings (Grocke & Wigram, 2006; Kabat-Zinn, 2009). However, as mentioned before, there are different levels of emphasis on the stresses faced in schooling by young people. School life is very different in Korea from the UK and problems relating to stress are very significant in Korea because of competition and pressure as a result of study. Many studies have shown that using music, RTs and meditation can help manage the pressures of learning and school life and help to revive minds to a bright and healthy state after students experience high levels of stress in school (Hong & Yeo, 2010; Kim, 2011). Compared to Korea, in the UK, there is greater emphasis on stress in general and the use of RM, MM and RTs for everyone. Therefore, there may be cultural differences related to the purposes of use of RM, MM and RTs.

Limitations

During the interviews, specific topics would be mentioned by practitioners from only one of the two countries, or else by one group of practitioners, that would otherwise have been valuable to analyse more fully. Some of the discussion therefore reflected the thoughts of one group in particular and this may be regarded as a limitation. Of course, if any practitioner was unwilling to talk about a specific question, it was inappropriate to pressure them into talking and so with some topics interview data needed to be analysed in a one-sided way. Examples of such topics include 'financial support and practice', and 'guidance and practice'.

CONCLUSIONS AND RECOMMENDATIONS

South Korea and the UK represent different cultural models of healthcare service and different approaches to interventions. Despite these different perspectives, beliefs, tendencies and religious influences, practitioners are commonly aware of the importance of knowledge sharing and benefits of integrating Eastern and Western practices in terms of their use of interventions and integrated medicine. For example, in its use of RM, MM and RTs, 'multidisciplinary integrated care' has become established in music therapy in both the UK and Korea. Like other professional practitioners, music therapists build relationships and networks and share across the worldwide community. As such RM, MM and RTs are clear examples of interventions that are currently and will increasingly be used in combination, drawing on practices in other countries. Therefore, by uncovering the ideas that underline UK and Korean practice, this study contributes towards both the body of research on multidisciplinary integrated care and cross-cultural healthcare research within this growing area. This paper shows the differences and similarities in use of RM, MM and RTs and how these can be affected by differing cultural and healthcare contexts.

To the first author's knowledge, this is the first qualitative and comparative case study of RM, MM and RTs within the specific context of South Korean and UK healthcare. This study is exploratory and broad in scope, an approach which is common in qualitative research where there is little existing research and where a key contribution made can be developing understanding and the meaning of particular social practices. The UK and South Korea have distinctive strengths in their use of mind-body-spirit interventions. In the future, through the growth of cross-cultural dialogue, the practitioner can learn from their respective strengths within their existing healthcare frameworks. In relation to cross-cultural points of comparison, there are various topics that can be taken up again and built on by future researchers such as cross-cultural qualitative research and integrating theory and practice.

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REFERENCES

Arias, A.J., Steinberg, K., Banga, A., & Trestman, R.L. (2006). Systematic review of the efficacy of meditation techniques as treatments for medical illness. *Journal of Alternative & Complementary Medicine*, *12*(8), 817-832.

BBC News. (2016). *Can mindfulness improve pupils' concentration?* https://www.bbc.com/news/magazine-35688048

BBC News. (2018). *World mental health day: What is mindfulness?* https://www.bbc.co.uk/news/uk-45815679

Beauchemin, J., Hutchins, T. L., & Patterson, F. (2008). Mindfulness meditation may lessen anxiety, promote social skills, and improve academic performance among adolescents with learning disabilities. *Complementary Health Practice Review, 13*(1), 34-45.

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

Bonny, H. (2001). Music psychotherapy: Guided imagery and music. *Voices: A World Forum for Music Therapy, 10*(3). https://doi.org/10.15845/voices.v10i3.568

Bonny, H.L., & Savary, L.M. (1990). *Music & your mind: Listening with a new consciousness*. Station Hill Pr.

Bradt, J., Dileo, C., & Potvin, N. (2013). Music for stress and anxiety reduction in coronary heart disease patients. *Cochrane Database of Systematic Reviews*, *12*, 1-104.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

British Association for Music Therapy. (2019). *History.* https://www.bamt.org/about-british-association-for-music-therapy/history.html

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

Buswell, R. E. (1993). *The Zen monastic experience: Buddhist practice in contemporary Korea*. Princeton University Press.

Carlson, L.E., Speca, M., Patel, K.D., & Goodey, E. (2004). Mindfulness-based stress reduction in relation to quality of life, mood, symptoms of stress and levels of cortisol, dehydroepiandrosterone sulfate (DHEAS) and melatonin in breast and prostate cancer outpatients. *Psychoneuroendocrinology*, *29*(4), 448-474.

Chen, K. W., Berger, C. C., Manheimer, E., Forde, D., Magidson, J., Dachman, L., & Lejuez, C. W. (2012). Meditative therapies for reducing anxiety: A systematic review and meta-analysis of randomized controlled trials. *Depression and Anxiety, 29*(7), 545-562.

Chiesa, A., & Serretti, A. (2009). Mindfulness-based stress reduction for stress management in healthy people: a review and meta-analysis. *The Journal of Alternative and Complementary Medicine*, *15*(5), 593-600.

Choi, A. N., Lee, M. S., & Lim, H. J. (2008). Effects of group music intervention on depression, anxiety, and relationships in psychiatric patients: A pilot study. *The Journal of Alternative and Complementary Medicine, 14*(5), 567-570.

Coleman, J.W. (2002). *The new Buddhism: The western transformation of an ancient tradition.* Oxford University Press.

Crane, R. S., & Kuyken, W. (2013). The implementation of mindfulness-based cognitive therapy: Learning from the UK health service experience. *Mindfulness, 4*(3), 246-254.

Davidson, R.J., Kabat-Zinn, J., Schumacher, J., Rosenkranz, M., Muller, D., Santorelli, S.F., Urbanowski, F., Harrington, A., Bonus, K., & Sheridan, J.F. (2003). Alterations in brain and immune function produced by mindfulness meditation. *Psychosomatic Medicine*, *65*(4), 564-570.

Davidson, J.M. (1976). The physiology of meditation and mystical states of consciousness. *Perspectives in Biology and Medicine*, *19*(3), 345-380.

Dhungel, K. U., Malhotra, V., Sarkar, D., & Prajapati, R. (2008). Effect of alternate nostril breathing exercise on cardiorespiratory functions. *Nepal Medical College Journal*, *10*(1), 25-27.

Diaz, F. M. (2013). Mindfulness, attention, and flow during music listening: An empirical investigation. *Psychology of Music*, *41*(1), 42-58.

Dobkin, P. L. (2008). Mindfulness-based stress reduction: what processes are at work? *Complementary Therapies in Clinical Practice*, *14*(1), 8-16.

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

Evans, D. (2002). The effectiveness of music as an intervention for hospital patients: A systematic review. *Journal of Advanced Nursing*, *37*(1), 8-18.

Goodman, K. D. (Ed.). (2015). *International perspectives in music therapy education and training: Adapting to a changing world*. Charles C Thomas Publisher.

Goldberg, F. S. (2013). The bonny method of guided imagery and music. In T. Wigram, B. Saperston & R. West (Eds.), *The art and science of music therapy: A handbook* (pp. 112-128). Routledge.

Gootjes, L., Franken, I. H., & Van Strien, J. W. (2011). Cognitive emotion regulation in yogic meditative practitioners sustained modulation of electrical brain potentials. *Journal of Psychophysiology*, *25*(2), 87-94.

Greenland, S. K. (2015). *Teaching mindfulness skills to kids and teens.* Guilford Publications.

Grocke, D., & Wigram, T. (2006). *Receptive methods in music therapy: Techniques and clinical applications for music therapy clinicians, educators and students*. Jessica Kingsley Publishers.

Guzzetta, C. E. (1991). Music therapy: Nursing the music of the soul. *Music Physician for Times to Come*, 146-166.

Guzzetta, C.E. (2000). Music therapy: Healing the melody of the soul. In B. Dossey, L.Keegan, & C.Guzzetta. (Eds). *Holistic nursing: A handbook for practice* (3rd edition) (pp.585-610). Aspen Publishers.

Hanh, TN. (2008). *The miracle of mindfulness: The classic guide to meditation by the world's most revered master.* Random House.

Hanser, S. B. (2014). Music therapy in cardiac health care: Current issues in research. *Cardiology in Review*, *22*(1), 37-42.

Hong, E. J., & Yeo, J. Y. (2010). A meta-analysis of the effects of children and adolescent group music therapy. *Korean Journal of Human Ecology*, *19*(5), 835-844.

Horton, J., Macve, R., & Struyven, G. (2004). Qualitative research: Experiences in using semi-structured interviews. In C. Humphrey & B. Lee (Eds.), *The real life guide to accounting research* (pp. 339-358). Elsevier.

Hubbard, K., & Falco, F.J.E. (2015). Relaxation techniques. In A. Kaye, N. Vadivelu & R. Urman (Eds.), *Substance Abuse* (pp. 337-347). Springer.

Hwang, M.H. (2018). *Health practitioners' understanding and use of relaxation techniques (rts), mindfulness meditation (mm) and relaxation music (rm) in the UK and South Korea: A qualitative case study approach* (Unpublished doctoral dissertation, University of the West of England, Bristol, UK).

Jacobs, G.D. (2001). Clinical applications of the relaxation response and mind-body interventions. *The Journal of Alternative & Complementary Medicine*, *7*(1), 93-101.

Janesick, V.J. (2016). *Contemplative qualitative inquiry: Practicing the Zen of research*. Routledge.

Jorm, A. F., & Wright, A. (2007). Beliefs of young people and their parents about the effectiveness of interventions for mental disorders. *Australian and New Zealand Journal of Psychiatry*, *41*(8), 656-666.

Kabat-Zinn, J., Lipworth, L., & Burney, R. (1985). The clinical use of mindfulness meditation for the self-regulation of chronic pain. *Journal of behavioral Medicine, 8*(2), 163-190.

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology: Science and Practice, 10*(2),144-156.

Kabat-Zinn, J. (2009). *Wherever you go, there you are mindfulness meditation in everyday life.* Hachette Books.

Kamioka, H., Tsutani, K., Yamada, M., Park, H., Okuizumi, H., Tsuruoka, K., Honda, T., Okada, S., Park, S.J., Kitayuguchi, J., & Abe, T. (2014). Effectiveness of music therapy: A summary of systematic reviews based on randomized controlled trials of music interventions. *Patient Preference and Adherence*, *8*, 727-754.

Kang, Y. S., Choi, S. Y., & Ryu, E. (2009). The effectiveness of a stress coping program based on mindfulness meditation on the stress, anxiety, and depression experienced by nursing students in Korea. *Nurse Education Today, 29*(5), 538-543.

Kavak, F., Ünal, S., & Yılmaz, E. (2016). Effects of relaxation exercises and music therapy on the psychological symptoms and depression levels of patients with schizophrenia. *Archives of Psychiatric Nursing, 30*(5), 508-512.

Kim, J. H. (2004). What is mindfulness?: Suggestions for clinical and everyday application of mindfulness. *Korean Journal of Health Psychology, 9*, 511-538.

Kim, S. A. (2014). Introduction to the 13th world congress of music therapy in Seoul, Korea. *Voices: A World Forum for Music Therapy*, *14*(1). https://doi.org/10.15845/voices.v14i1.748

Kim, S. H. S. (2011). The development and the effectiveness of an integrative group counseling program for depression, suicide ideation, and stress in high school students. *Korean Journal of Child Studies*, *32*(6), 81-94.

Klainin-Yobas, P., Oo, W.N., Suzanne Yew, P.Y., & Lau, Y. (2015). Effects of relaxation interventions on depression and anxiety among older adults: A systematic review. *Aging & Mental Health*, *19*(12), 1043-1055.

Krisanaprakornkit, T., Sriraj, W., Piyavhatkul, N., & Laopaiboon, M. (2006). Meditation therapy for anxiety disorders. *Cochrane Database of Systematic Reviews*, *1*. https://doi.org/10.1002/14651858.CD004998.pub2.

Krusche, A., Cyhlarova, E., King, S., & Williams, J. M. G. (2012). Mindfulness online: A preliminary evaluation of the feasibility of a web-based mindfulness course and the impact on stress. *BMJ Open, 2*(3). http://bmjopen.bmj.com/content/2/3/e000803.full.html.

Kwekkeboom, K.L., Cherwin, C.H., Lee, J.W., & Wanta, B. (2010). Mind-body treatments for the pain-fatigue-sleep disturbance symptom cluster in persons with cancer. *Journal of Pain and Symptom Management, 39*(1), 126-138.

Lee, K., Jeong, H., Yim, J., & Jeon, M. (2016). Effects of music therapy on the cardiovascular and autonomic nervous system in stress-induced university students: A randomized controlled trial. *The Journal of Alternative and Complementary Medicine, 22*(1), 59-65.

Lesiuk, T. (2016). The development of a mindfulness-based music therapy (MBMT) program for women receiving adjuvant chemotherapy for breast cancer. In *Healthcare*, *4*(3), 53-67.

Li, D. (1998). "It's always more difficult than you plan and imagine": Teachers' perceived difficulties in introducing the communicative approach in South Korea. *TESOL quarterly*, *32*(4), 677-703.

Liu, H., Gao, X., & Hou, Y. (2019). Effects of mindfulness-based stress reduction combined with music therapy on pain, anxiety, and sleep quality in patients with osteosarcoma. *Brazilian Journal of Psychiatry*, *41*(6), 540-545.

Marconato, C., Munhoz, E. C., Menim, M. M., & Albach, M. T. (2001). Application of receptive music therapy in internal medicine and cardiology. *Arquivos Brasileiros de Cardiologia, 77*(2), 140-141.

Marx, R., Strauss, C., & Williamson, C. (2015). Mindfulness apprenticeship: A new model of NHS-based MBCT teacher training. *Mindfulness*, *6*(2), 253-263.

Masters degrees (Mindfulness). (2016). *FindAMasters.* https://www.findamasters.com/search/courses.aspx?keywords=mindfulness

McNamara, S. (2000). *Stress in young people: What's new and what to do*. A&C Black.

Mindfulness. (2018). In *Merriam-Webster Online*. https://www.merriam-webster.com/dictionary/mindfulness

Mitchell, M. (2009). Emotional freedom technique. *The Practising Midwife, 12*(7), 12-14.

Mowat, J. G. (2010). Towards the development of self-regulation in pupils experiencing social and emotional behavioural difficulties (SEBD). *Emotional and Behavioural Difficulties, 15*(3), 189-206.

Nilsson, U. (2004). Music and health: How to use music in surgical care. In A. Dilani (Ed.), *Design & health III: Health promotion through environmental design* (pp.103-109). International Academy for Design and Health.

Paul, B., & Ian, G. (2010). *Meditation.* Penguin Random House.

Pihl, M. R. (1995). Koryŏ sŏn buddhism and korean literature. *Korean Studies, 19*(1), 62-82.

Radnor, H. A. (1994). *Collecting and analysing interview data.* Research Support Unit, School of Education, University of Exeter.

Robb, S. L. (2000). Music assisted progressive muscle relaxation, progressive muscle relaxation, music listening, and silence: A comparison of relaxation techniques. *Journal of Music Therapy*, *37*(1), 2-21.

Robb, S. L., Nichols, R. J., Rutan, R. L., Bishop, B. L., & Parker, J. C. (1995). The effects of music assisted relaxation on preoperative anxiety. *Journal of Music Therapy*, *32*(1), 2-21.

Ruud, E. (2008). Music in therapy: Increasing possibilities for action. *Music and Arts in Action*, *1*(1), 46-60.

Seth, M. J. (2010). *A history of Korea: From antiquity to the present*. Rowman & Littlefield Publishers.

Shapiro, D. H., & Giber, D. (1978). Meditation and psychotherapeutic effects: Self-regulation strategy and altered state of consciousness. *Archives of General Psychiatry*, *35*(3), 294-302.

Shapiro, D. H., & Zifferblatt, S. M. (1976). Zen meditation and behavior self-control: Similarities, differences, and clinical applications. *American Psychologist, 31*(7), 519-532.
Smith, M. (2008). The effects of a single music relaxation session on state anxiety levels of adults in a workplace environment. *Australian Journal of Music Therapy*, *19*, 45-66.
Speca, M., Carlson, L. E., Goodey, E., & Angen, M. (2000). A randomized, wait-list controlled clinical trial: The effect of a mindfulness meditation-based stress reduction program on mood and symptoms of stress in cancer outpatients. *Psychosomatic Medicine, 62*(5), 613-622.
Suh, S. A. (2012). *Being Buddhist in a Christian world: Gender and community in a Korean American temple.* University of Washington Press.
Summer, L. (2002). Group music and imagery therapy: Emergent receptive techniques in music therapy practice. In K.E. Bruscia and D.E Grocke (Eds.), *Guided imagery and music: The Bonny method and beyond*. Barcelona Publishers.
Summer, L. (2011). Client perspectives on the music in guided imagery and music (GIM). *Qualitative Inquiries in Music Therapy*, *6*, 34-74.
Summer, L. (2015). The journey of GIM training from self-exploration to a continuum of clinical practice. *Guided Imagery & Music (GIM) and Music Imagery Methods for Individual and Group Therapy*, 339-348.
Suzuki, S. (1973). *Zen mind beginner's mind.* Weatherhill.

Thaut, M. H. (1989). The influence of music therapy interventions on self-rated changes in relaxation, affect, and thought in psychiatric prisoner-patients, *Journal of Music Therapy*, *26*(3), 155-166.
Thaut, M. H., & Davis, W. B. (1993). The influence of subject-selected music versus experimenter-chosen on affect, anxiety, and relaxation, *Journal of Music Therapy, 30*, 210-233.
Toneatto, T., & Nguyen, L. (2007). Does mindfulness meditation improve anxiety and mood symptoms? A review of the controlled research. *Canadian Journal of Psychiatry, 52*(4), 260-266.
The Music Education News. (2019). *Music therapy: An interview with professor choi byung-chul.* http://www.musiced.co.kr/bbs/board.php?tbl=interview&mode=VIEW&num= 1890&findWord=%C3%D6%BA%B4%C3%B6
Vøllestad, J., Sivertsen, B., & Nielsen, G. H. (2011). Mindfulness-based stress reduction for patients with anxiety disorders: Evaluation in a randomized controlled trial. *Behaviour Research and Therapy, 49*(4), 281-288.
Walsh, R., & Shapiro, S. L. (2006). The meeting of meditative disciplines and western psychology: A mutually enriching dialogue. *American Psychologist*, *61*(3), 227-239.
Weick, K. E., & Putnam, T. (2006). Organizing for mindfulness: Eastern wisdom and western knowledge. *Journal of Management Inquiry, 15*(3), 275-287.
Weaver, A.J., Vane, A. and Flannelly, K.J. (2008). A review of research on Buddhism and health: 1980–2003. *Journal of Health Care Chaplaincy*, *14*(2), 118-132.
West, M. (1979). Meditation. *The British Journal of Psychiatry*, *135*(5), 457-467.
Williams, D. A., & Carey, M. (2003). *You really need to relax: Effective methods.* University of Michigan.
Williams, J. M. G. (2008). Mindfulness, depression and modes of mind. *Cognitive Therapy and Research, 32*(6), 721-733.
Wilson, J. (2014). *Mindful America: Meditation and the mutual transformation of buddhism and American culture.* Oxford University Press.
Winbush, N. Y., Gross, C. R., & Kreitzer, M. J. (2007). The effects of mindfulness-based stress reduction on sleep disturbance: A systematic review. *Explore*, *3*(6), 585-591.
Wolfe, D. E., O'Connell, A. S., & Waldon, E. G. (2002). Music for relaxation: A comparison of musicians and nonmusicians on ratings of selected musical recordings. *Journal of Music Therapy, 39*(1), 40-55.
Yin, R. (2003). *Case Study Research: Design and Methods* (5th ed.). Sage.

Ελληνική περίληψη | Greek abstract

Μουσική Χαλάρωσης (ΜΧ), Ενσυνείδητος Διαλογισμός (ΕΔ) και Τεχνικές Χαλάρωσης (ΤΧ) στην φροντίδα υγείας: Μία ποιοτική μελέτη περίπτωσης των πρακτικών που ακολουθούνται στο Ηνωμένο Βασίλειο και την Νότια Κορέα

Mi Hyang Hwang | Leslie Bunt

ΠΕΡΙΛΗΨΗ

Η Μουσική Χαλάρωσης (Relaxation Music - MX), ο Ενσυνείδητος Διαλογισμός (Mindfulness Meditation - ΕΔ) και οι Τεχνικές Χαλάρωσης (Relaxation Techniques - ΤΧ) χρησιμοποιούνται ευρέως σε πλαίσια υγειονομικής περίθαλψης και αυτές οι παρεμβάσεις έχουν διερευνηθεί στην ολοκληρωμένη υγειονομική περίθαλψη, στην ψυχοθεραπεία καθώς και σε συνεργατικές και διεπιστημονικές προσεγγίσεις. Ωστόσο, η ανταλλαγή

πληροφοριών ανάμεσα σε επαγγελματίες υγείας του Ηνωμένου Βασιλείου και της Νότιας Κορέας είναι έως τώρα περιορισμένη και οι διαπολιτισμικές συγκρίσεις των παρεμβάσεων ΜΧ, ΕΔ και ΤΧ στο πλαίσιο υγειονομικής περίθαλψης του Ηνωμένου Βασιλείου και της Κορέας δεν έχουν διερευνηθεί μέχρι σήμερα. Στόχος του παρόντος άρθρου είναι να παρουσιάσει συνοπτικά τις βασικές πτυχές μίας αδημοσίευτης διδακτορικής διατριβής (Hwang, 2018). Το άρθρο επικεντρώνεται στη διερεύνηση των ομοιοτήτων και των διαφορών στην κατανόηση της χρήσης των παρεμβάσεων ΜΧ, ΕΔ και ΤΧ μεταξύ των επαγγελματιών στο Ηνωμένο Βασίλειο και στην Κορέα. Ακολουθώντας ποιοτική μεθοδολογία μελέτης περίπτωσης, η συλλογή δεδομένων έγινε μέσα από ημι-δομημένες συνεντεύξεις με έξι Κορεάτες και έξι Βρετανούς επαγγελματίες υγείας σε τρείς περιοχές επαγγελματικής δραστηριότητας: ιατρική, διαλογισμό και μουσικοθεραπεία. Από την ανάλυση προέκυψαν ομοιότητες (σε προοπτικές και σκοπούς, μεθόδους, ενδιαφέροντα και προβληματισμούς, τρόπους ανταπόκρισης και προσεγγίσεις) και διαφορές (σε ιστορικές και παραδοσιακές επιρροές, μοτίβα συμπεριφοράς και ιδιαίτερες επισημάνσεις). Η αξία της διαπολιτισμικής και διεπιστημονικής έρευνας αναγνωρίζεται ολοένα και περισσότερο και οι ΜΧ, ΕΔ και ΤΧ ως θεραπευτικές παρεμβάσεις για το τρίπολο νους-σώμα-πνεύμα εκτιμώνται ως χρήσιμες ολοκληρωμένες παρεμβάσεις. Το παρόν άρθρο συνεισφέρει στη διαπολιτισμική ποιοτική έρευνα ανάμεσα στη Νότια Κορέα και το Ηνωμένο Βασίλειο και την ενοποίηση θεωρίας και πρακτικής των παρεμβάσεων ΜΧ, ΕΔ και ΤΧ.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

μουσική χαλάρωσης, ενσυνείδητος διαλογισμός, τεχνικές χαλάρωσης, φροντίδα υγείας, Ηνωμένο Βασίλειο, Νότιος Κορέα, διαπολιτισμική έρευνα

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ARTICLE

Who's afraid of Christian Wolff? Exploring experimental music on an acute inpatient adolescent psychiatric unit

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ABSTRACT

In this practice-based article, the author summarises how he explored experimental music with creative arts-curious adolescent patients to help improve interpersonal interactions, impulse control, compliance, and attentional needs. Informed by the American composer of experimental classical music Christian Wolff, the author constructed an original clinical experimental music composition, *Burdock Variations and Other Wolff*, to be recreated in music therapy group settings on an acute psychiatric unit. Unexpectedly, the results of the experimental music group therapy experience revealed that (a) while aesthetic needs and development were not part of the patients' treatment team goals, the experimental musical experience played an indispensable role in cultivating, shaping, and meeting the *aesthetic needs* of each patient in a safe therapeutic environment, (b) due to challenging the teens' *aesthetic system* (Curreri, 2013) by exploring new and unusual sound practices together, the therapeutic relationship that had been developing in more standard music and other creative arts interventions deepened between the teens and the author, (c) the *Burdock Variations and Other Wolff* exploration is an *advanced* music therapy intervention that should be introduced after more standard music therapy interventions have been explored, and (d) the *Burdock Variations and Other Wolff* exploration should only be introduced to the adolescent patients that are able to remain focused, curious, and attentive.

KEYWORDS

adolescents,
acute inpatient psychiatry,
experimental music,
Christian Wolff,
re-creative experience,
aesthetics

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I'm trying to see how little I can indicate and yet come up
with a piece that's clearly itself, one that still has a life of its own.
Christian Wolff, *1994*

INTRODUCTION

During a group discussion following a free-music improvisational exploration that was centred on cultivating self-expression, identity formation, and interpersonal skills, the adolescent psychiatric patients unexpectedly became animated after the author of this current practice-based article used

the term "experimental music". The author quickly discovered that the novelty-seeking teens' excitement was due to their associating the term "experimental" with "experimental drugs". After the patients' polite outbursts subsided, the author highlighted that he was not speaking about experimenting with drugs, but rather, experimenting with sounds. Suddenly, the teens' curiosity shifted. The patients were eager to find out about experimental music and how it differed from the free-music improvisational experience that had just occurred. The author stressed that improvisational and experimental musical experiences are not interchangeable (Gottschalk, 2016), and are often confused with each other (Bailey, 1993; Cage, 1961), where both improvisational (Bruscia, 2014; Wigram, 2004) and experimental (Bailey, 1993; Gottschalk, 2016; Lucier, 2012) music carry a variety of definitions, possibly causing confusion to the uninitiated. As the conversation continued with the teens, the author discussed different approaches that informed his music therapy practice, helping to clarify when it was clinically appropriate to use either improvisational or experimental musical experiences with acute adolescent psychiatric patients.

Clinical music improvisation

Informed by music therapy literature (Ahonen-Eerikäinen, 2007; Alvin & Warwick, 1991; Bruscia, 1987, 2014; Gardstrom, 2007; Lee, 2003; Nordoff & Robbins, 2007; Priestley, 1994; Wigram, 2004), the author of this present practice-based article (hereafter referred to as "clinician"), utilised improvisational tonal or atonal musical techniques (Wigram, 2004) to help the adolescent patients cultivate self–awareness and ego strength (Ahonen-Eerikäinen, 2007; Priestley, 1994), express feeling-states, moods, emotions, and imagery (Gardstrom, 2007), as well as to develop self-expression and identity formation (Bruscia, 2014; Nordoff & Robbins, 2007). Specifically, the clinician encouraged the teens to freely explore musical elements, such as harmony, melody, dynamics, rhythm, timbre, etc., when creating *referential* (extemporising music/vocals with reference to feelings, moods, emotions, image, story, etc.), or *non-referential* (extemporising music/vocal without reference) music/sound improvisations (Bruscia, 2014; Gardstrom, 2007). Interestingly, one noticeable feature of the referential and non-referential improvisations created by the above-mentioned group of adolescent patients was that the teens' improvisations consciously/unconsciously embodied their personalities, tastes, likes, dislikes, preferences, and conventionalities. Consequently, these group music improvisations informed the clinician how the teens *functioned in* and *responded to* the world interpersonally and intrapersonally (Ahonen-Eerikäinen, 2007; Bruscia, 1998; Nordoff & Robbins, 2007), undoubtedly a unique and robust feature of clinical music improvisation (Bruscia, 1987; Wigram, 2004).

Furthermore, the above-mentioned adolescent patients and the clinician discussed how music improvisation was used to meet their clinical needs and explore how obstacles were affecting their daily lives (Bruscia, 2014). As the conversation shifted to the question at hand, regarding the differences between improvisational and experimental musical experiences, the clinician underlined that experimental music, unlike improvisational music, is not concerned with personalities, tastes, likes, or dislikes (Duckworth, 1995; Nyman, 1999; Retallack, 1996; Revill, 1992), and, especially, musical conventionality (Cage, 1961; Kostelanetz, 1989, 1996). In fact, Curreri (2013) reports that using experimental music clinically has the potential to challenge the patient's *aesthetic system* by

frustrating expectations, preferences, tastes, likes, and dislikes due to catapulting the patient into unconventional musical/sound experiences.

Clinical experimental music

Regrettably, music therapy literature reporting on the clinical use of experimental and indeterminate music is lacking (Curreri, 2013, 2015). Consequently, the clinician's music therapy practice with adolescent patients was informed by musicological research on experimental music/sound practices outside of the field of music therapy, examining experimental music historically (Gottschalk, 2016; Holmes, 2015; Nyman, 1999; Rutherford-Johnson, 2017), as well as the practices of composers of experimental music (Cage, 1961; Duckworth, 1995; Hicks & Asplund, 2012; Lucier, 2012).

The practice of experimental music is difficult to categorise, and lacks a specific school of thought, or aesthetic stance (Gottschalk, 2016). According to Cage (1961), experimental music is not concerned with self-expression, but rather, *self-alteration* (Kostelanetz, 1989, 1996; Retallack, 1996; Revill, 1992), where surprises and discoveries are welcomed and explored (Lucier, 2012), possibly expanding one's perception of potentials and possibilities (Gottschalk, 2016). Therefore, to give the above-mentioned adolescent patients clinical context, the clinician explained that a music therapy group focusing on an experimental musical/sound-based exploration would centre on inquiry, openness, uncertainty, and discovery (Holmes, 2015; Nyman, 1999). The clinician stressing that an experimental music experience requires a readiness to let go of control, personal agenda, and judgment in order to openly observe sounds as they materialise (Curreri, 2013), adding that the unknown outcome of the experimental music composition could be regarded as more important than the composer's intentions (Gottschalk, 2016; Lucier, 2012).

After hearing the clinician's explanation of experimental music, the quasi-perplexed adolescent patients were eager to "try out" an experimental music/sound intervention "together" in a therapeutic setting in order to "completely understand" the non-ordinary musical experience. Moreover, the teens insisted on having the clinician or "the expert…write the music for the group". The clinician openly applauded the teens for wanting to explore experimental music clinically, adding that it was a positive and safe way to stimulate and arouse their novelty-seeking behaviours. Moreover, the clinician expressed how he was not surprised by the teens' interest in experimental music/sound practices because this particular group of adolescent patients was inquisitive, intelligent, and creative arts-curious.

Composer Christian Wolff

Once the clinician was asked to write an experimental piece of music for the adolescent patients, he immediately thought of the composer of experimental classical music Christian Wolff (b.1934), due to Wolff's compositions having the ability to turn music-making into a collaborative, transforming, and altering experience for the performers (Gottschalk, 2016). For example, in his compositions *Prose Collection* (1969/71/85), *Edges* (1968), *For 1, 2, or 3 People* (1964), and *Exercises* (1973-), Wolff's directives involve the performers having to frequently *change roles* during the composition (Gottschalk, 2016; Hicks & Asplund, 2012), while remaining in the role of a "musician". Moreover, the

aforementioned Wolff scores require a performer to play in a specific way as an outcome of another performer unpredictably playing a directive in a specific way (Hicks & Asplund, 2012). Consequently, the clinician speculated that a musical score constructed in the "style" of Wolff would offer the novelty-seeking adolescent patients the opportunity to explore new and unusual sounds and textures in a safe, therapeutic, non-judgmental environment, and have a chance to interpret the same piece of music in different ways, resulting in varied and diverse outcomes (Gottschalk, 2016). Furthermore, within the Wolff-informed experimental musical experience, the teens would possibly encounter the "uncomfortable" and "unexpected" anxiety-causing social situations that they feared in everyday life, including shared engagement, commitment, and independent and collective decision-making (Hicks & Asplund, 2012), as well as indulging in experiences that had been prohibited or silenced by their guardians, such as creative freedom, and the dismantling of hierarchies. Lastly, the clinician speculated that the balancing of both *freedom* and *constriction*, which occurs so frequently in Wolff's compositions (Duckworth, 1995; Hicks & Asplund, 2012), could create an environment that would give the adolescent patients an opportunity to reflect on these two contrasting experiences rather than remaining in one or the other for the entirety of the composition.

Clinical approach

Patients and setting

The unit was part of a teaching hospital in a large, culturally and religiously diverse area in the eastern region of the United States. The unit was designed for the diagnosis and treatment of all adolescent psychiatric disorders. The range of diagnoses included mood disorder, anxiety disorder, substance abuse, disruptive behaviour disorder, post-traumatic stress disorder, and autism spectrum disorder; and the unit provided crisis stabilisation, medication adjustment, and integrative-multicultural psychotherapeutic family and patient interventions. All interventions were focused on the resolution of acute symptoms and community reintegration for the patient. A patient typically remained on inpatient status for three to seven days, and was considered to be ready for discharge when he/she could receive safe and proper care in a less restrictive setting. Moreover, the patients on the unit were scheduled to attend a variety of daily psychosocial and psychoeducational programming sessions, as well as attend the high school on the hospital premises.

Following institutional guidelines, all patients and their guardians signed a letter of informed consent describing that session data could be used for a review or report (non-research), wherein after completion of the review, all session data must be shredded and/or erased.

Christian Wolff-informed experimental music experience

Goals

While creating the Wolff-informed experimental music composition presented in this paper, the clinician set a goal outside of the priority goals in each of the adolescent patients' treatment plans tailored by the integrated treatment team: to provide a fulfilling open-ended non-ordinary experience. This open-ended goal would allow the teens to explore and develop his/her own process via

discovery, observation, and insight, while engaging in the Wolff-informed non-ordinary musical experience (see Table 1).

Presentation

The clinician presented his original composition *Burdock Variations and Other Wolff* to the adolescent psychiatric patients in an early morning two-hour music psychotherapy group session, making the prolonged weekend group time conducive for exploring an experimental piece of music multiple times in one group session. After greeting the patients and reciting the group rules together, the clinician gave a brief description of composer Christian Wolff's music and philosophy, including providing them with a printout of a short biography and photograph of Wolff, explaining to the teens that Wolff's music was the inspiration behind the *Burdock Variations and Other Wolff* composition.

Explorations

The following are brief descriptions of the three *Burdock Variations and Other Wolff* explorations that took place in the music psychotherapy group session mentioned above. Moreover, the last part of the session was reserved for the patients to verbally process their thoughts, emotions, and feeling states about the Wolff-informed musical explorations. The dialogues, procedures, and the overall group process explained below are based on the clinician's written session notes taken before, during, and after the Wolff intervention.

Exploration # 1

All of the patients were given a copy of the score. Looking confused, they discussed the format amongst themselves and asked the clinician to clarify some of the musical terminology and the meaning of the time brackets. As the clinician predicted, the patients were focused on "doing things right", concerned with "making good music", and "not messing things up". The teens decided not to have a conductor and opted to play the composition in sequence "to see what will happen". After picking their musical instruments, they worked through the composition uneventfully, creating an apprehensive, hurried, and restrained sonic experience.

Exploration # 2

After some playful quarrelling, the patients picked one group member to be the "conductor". The patient-conductor decided to "run things in sequence". Again, similar to their first exploration, the patients rushed through each of the sound-based events, due to the patient-conductor frantically signalling to the group members when to stop and start their parts, leaving little room for silences. The outcome of this sonic exploration was rushed, panicky, and uneventful.

Exploration # 3.A

The patients were visibly frustrated. The clinician asked them to work through their frustration by talking to each other about "what" they were experiencing in the moment. The teens concluded that their "experience of things" was a "musical mess". They asked for the clinician's insights. The clinician asked the patients to meditate on how they approached the composition and to examine each "unique" musical outcome that developed. The teens became dismissive, attacking the

composition itself "because it makes garbage music". After the outburst subsided, the patients opted to try the composition again. They came to a group decision to have the clinician conduct the experimental composition because he had "experience with this type of music". The clinician accepted their request.

Burdock Variations and Other Wolff

A composition for any number of teens on the unit

(*Adapted from various compositions by composer Christian Wolff*)

- Pick any instrument(s) that you want to use for this group musical construction.
- Please look over the score (directives) together and discuss how the composition will function.
- Is it necessary to play the directives in order? Please consider if each part will be played simultaneously, in sequence, or overlapped. However, # 4 MUST always be 4th in any order. Should things be repeated?
- Please discuss if you will need a "conductor" or a timekeeper. Or, should each player keep his or her own time?
- If needed, ask (Author) for help, guidance, or definitions of terms.

Begin Somewhere:

→For 40"----------
1) Play **1** pitch on **1**instrument→ Create **4** different colors or timbre. (Loud and/or soft dynamics)

→For 1'58"----------
2) Each participant will create **1** to **4** very, very soft sounds on 1 instrument, coordinating each sound with every other participant in succession

→For 1'03"----------
3) Play **1** pitch on **1** instrument→ Create **5** different colors or timbre **or** create **1** vocal sound using only **1** timbre.

→For 1'46"----------
4) Create **6** sounds (plus **2** "bent" pitches that only sound once apiece)

→For 3'03"----------
5) Create **7** sounds (while keeping your ears open to what others are doing). (Very loud and/or soft dynamics)

→For 20"----------
6) Group plays a pitch simultaneously as possible, but a "soloist" holds a note longer than the group. (Repeat as many times as needed **or** do not repeat)

→For 47"----------
7) Play only **1** pitch using only **1** timbre only **1** time→Listen to each other for ideas.

→For 1'02"----------
8) Play freely "as though you were getting **discharged** today"

→For 34"----------
9) "Silence"**.** Don't play anything. **Listen** to each other. Let environmental sounds occur.

Table 1: Burdock Variations and Other Wolff

Suddenly, the clinician realised that if he were to make any personal choices about *how* he should conduct *Burdock Variations and Other Wolff*, it would not be a *pure* experimental musical experience. However, it was turning out to be just that! The clinician pointed out to the patients that the experimental composition was becoming an "actual" experiment since they were observing and discovering what (a) was working, (b) was not working, and (c) was partly working. The clinician happily expressed to the patients that because of the outcome of their previous two re-creations of the composition, he should have created a chance-based or indeterminate conductor's score focusing on timekeeping and the selection of the prescribed actions. Consequently, the clinician decided to conduct the score by rolling dice to randomly pick each directive accordingly. The clinician informed the patients that he was curious to find out if the rolling of the dice would shape the composition in an interesting and unique way by *unintentionally* adding, for example, prolonged silences, simultaneity, overlapping of parts, and/or the repeating of sections. As a result of his curiosity and enthusiasm, the patients revealed that they were "starting to understand" the experimental musical process and how it was different from improvisation and self-expression.

Exploration # 3.B

The clinician took his time rolling the dice, creating a calm atmosphere that was void of hesitation. After each roll, he used different hand gestures to cue the patients, indicating when they should start and stop each written directive. Specifically, hand gestures were used to signal the group as a whole unit and to signal the patients individually. Consequently, the patients were noticeably less anxious and more relaxed when actively creating their parts. The outcome of this construction of *Burdock Variations and Other Wolff* consisted of a variety of soft and loud sounds, including brief moments of elevated dynamics, intense vocal chanting, and patients interacting with each other using pronounced body movements and unusual vocalisations.

Evaluation

During the verbal-processing section of the *Burdock Variations and Other Wolff* group exploration, the patients revealed their insights, perceptions, and feeling-states concerning their non-ordinary experience together. The patients' unrestricted goal set by the clinician, *to provide a fulfilling open-ended non-ordinary experience*, proved to be beneficial because context and experience were critical to helping the teens to understand what an experimental musical exploration would entail. Notably, despite the fact that their descriptions were brief and concise, common themes were explored from the teens' self-reports: *Unusual New Departures*, *Aesthetic Awareness*, and *Therapeutic Relationship*. Here, the clinician titled and categorised the themes to represent components of the Wolff-informed experimental music group therapy intervention that were meaningful to the above-mentioned adolescent patients.

Unusual new departures

All of the patients reported that the experimental music experience was "something that no other therapist or therapy on the unit [was] doing and exploring with us". The clinician concurred, emphasising that using experimental-music therapy was novel and an unexplored area of clinical practice (Curreri, 2013, 2015). Moreover, the patients expressed "how" they were "taken to a new

place" via the novel musical exploration, which "was not an emotional place" but "a mind-changing place", allowing them to "explore a different kind of music and sound". The teens expressed how they "weren't expecting the unexpected", due to being "caught off-guard" by the new musical departure. Consequently, a brief discussion surrounding "a different kind of listening" ensued, centring on how the sound-based experience frustrated the teens' expectations of "logical" musical construction and "order". To enhance their insights, the clinician stressed that Christian Wolff's composition teacher and colleague, John Cage, was interested in freeing sounds from conventionalities by abandoning all of his desire to control sound and music (Cage, 1961, 1967, 1973), and, like Wolff, was not concerned with personal experiences or preferences (Hicks & Asplund, 2012), but rather, with open experience (Kostelanetz, 1989).

Aesthetic awareness

As the adolescent patients continued to describe their new and unusual experiences, the teens' insights intrigued the clinician due to sounding as though there was an actual *shift in aesthetics* (Curreri, 2013) or the patients' perceptions of beauty. Consequently, the clinician spoke briefly about different aesthetic stances taken in improvisational music versus experimental music, particularly how the notion of "beauty" becomes deeply suspect during an experimental music exploration due to allowing the prescribed actions to unfold naturally in order to experience the unintentional sounds as they materialise together to discover the behaviour or action of the sound itself (Gottschalk, 2016).

Therapeutic relationship

According to the adolescent patients, the clinician "allowed" the teens "to explore" the experimental musical experience "freely" within a safe therapeutic environment. Particularly important to the adolescent patients was that a therapeutic relationship with the clinician developed "in a very easy" and "natural way". The patients emphasised "that this [experimental-musical experience] is a different thing than learning music at school or after school with a teacher" due to "you…[the clinician] working beside us", acting as "a partner" within the therapeutic process. The clinician acknowledged the patients' feelings and informed them that he was touched by their openness. Moreover, as the discussion unfolded, the clinician realised how important the therapeutic partnership was to the teens when they expressed deeply "how nice it would be to have a parent like you [the clinician] to do things with… like this crazy experience". The patients expressed "excitement" towards the clinician's openness to "new things" and wished their "parents would have these interests" and, most importantly, "just have an interest in us". Again, the clinician acknowledged and validated the patients' thoughts and feelings about their "disappointment" and "frustration" in the context of unsettling family dynamics.

Group's closing thoughts and behaviours

As the session ended, there was "excitement in the air" as the patients expressed how they wanted to "explore the experimental music again with you [the clinician] in the next session". The clinician resonated with their excitement, letting the patients know how delighted he was to see them so animated and enthusiastic. Interestingly, prior to this group of patients presented in this paper, not

many teens had expressed such interests in new and unusual music or creative arts in general; but this particular group of teens were verbally expressive, intelligent, inquisitive, and creative arts-curious.

FURTHER DEVELOPMENTS

In the next couple of group sessions, new patients arrived and were introduced to the experimental musical experience by the original patients mentioned above. With the new patients on board, lively discussions were evoked about "the possible different ways" of investigating *Burdock Variations and Other Wolff*, concentrating on (a) "just noticing and observing whatever happens" in each experience and "leaving it alone", (b) "[exploring] if the music turns out similar or different each time", or (c) treating the composition as a "true scientific experiment" that would lead to "another experiment, leading to another, and to another", discovering if the experimental musical experience "worked", "somewhat worked", or "did not work at all", treating *Burdock Variations and Other Wolff* as an ongoing process. Consequently, the patients and the clinician found the outcomes of these explorations not only "particularly interesting" musically, but "dramatically" as well. Moreover, the patients reported that the sound-based explorations produced feelings of "shared meaning", "pleasure", and "shared belonging".

However, unfortunately the patients' excitement and curiosity concerning experimental music came to an abrupt ending. This was due to the new patients that were admitted to the adolescent unit carrying a diagnosis of conduct disorder and ADHD. When the clinician introduced the *Burdock Variations and Other Wolff* group intervention to the new patients, they reported that they did not "want to get involved with this garbage". Moreover, the new patients stood outside of therapeutic circle with their hands in their pockets, shrugged-shouldered, while looking up at the ceiling or out of the window. This caused the otherwise enthusiastic group of patients to shut down and to abruptly leave the group without any explanation. Clinically, this was an important event because it gave the clinician perspective on the appropriateness of experimental music and which patients would respond best to experimental sound practices, explorations, and experiences.

SUGGESTIONS FOR FUTURE MUSIC THERAPISTS

As a result of the outcomes mentioned above, and further clinical explorations with acute adolescent patients not discussed in this practice-based article, the clinician suggests that the *Burdock Variations and Other Wolff* experimental music experience is an *advanced* music therapy intervention that should be introduced after a therapeutic relationship has developed between the patients and the music therapist in more standard music therapy interventions. For example, in the paper presented here, the clinician introduced experimental music to the patients after a therapeutic relationship had developed in free-music improvisational group experiences, as well as in projective drawing/painting, writing, or movement to music group explorations not mentioned in this paper. Consequently, the *Burdock Variations and Other Wolff* experience deepened the therapeutic relationship between the patients and the clinician. Therefore, future music therapists are invited to introduce the *Burdock Variations and Other Wolff* composition to psychiatric adolescent patients that

are able to remain focused, curious, and attentive throughout the duration of the experimental music experience.

Unfortunately, music therapy literature reporting on adolescent patients and aesthetic development via the exploration of experiential music/sound practices is lacking. Therefore, the clinician suggests that future music therapists explore the *Burdock Variations and Other Wolff* group music therapy intervention with adolescent psychiatric patients to help cultivate their *aesthetic needs* in a safe therapeutic environment, examining their perceptions of beauty and exploring realms *beyond the beautiful* (Lee, 2003).

Lastly, the clinician strongly suggests that future music therapists should be well accustomed to experimental music/sound practices, with the understanding that the experimental musical exploration should not be disrupted or interrupted by the music therapist's own likes, dislikes, and preferences.

AFTERTHOUGHTS

The results of the Christian Wolff-informed group music therapy intervention described in this practice-based article suggest that the experimental music intervention could benefit creative arts-curious adolescent psychiatric patients by activating aesthetic awareness and curiosity. Notably, the experimental music therapy intervention alone addressed the aesthetic needs of the teens, whereas aesthetics was not being addressed by the other disciplines on the psychiatric unit. Furthermore, this unique experimental musical experience allowed a therapeutic relationship to develop between the teens and the clinician, where the patients expressed an enthusiasm towards the clinician's openness to new and unusual ideas, and a deep sadness towards their parents' resistance of exploring new and unusual experiences with the teens. However, although the patients described having a rich group therapy experience, it must be stressed that the composite description in the evaluation section above was from one experimental-music therapy session only. This illuminates the fact that the acute psychiatric unit admitted and discharged teens so frequently, making it difficult for the same above-mentioned adolescent patients to continuously work and discover together in further closed experimental-music therapy sessions. Nevertheless, in the spirit of experimentation, as this present practice-based article described, when the new patients arrived, new discoveries unfolded. Consequently, future music therapists are invited to investigate the *Burdock Variations and Other Wolff* group music therapy intervention with adolescent psychiatric patients to explore a new and unusual way of cultivating shared engagement, connection, and meaning-making, especially if future music therapists have the opportunity to facilitate multiple closed group sessions over a longer period of time.

REFERENCES

Ahonen-Eerikäinen, H. (2007). *Group analytic music therapy*. Gilsum, NH: Barcelona Publishers.
Alvin, J., & Warwick, A. (1991) *Music therapy for the autistic child*. Oxford: Oxford University Press.
Bailey, D. (1992). *Improvisation: Its nature and practice in music*. New York: Da Capo Press, Inc.
Bruscia, K. (1987). *Improvisational models of music therapy*. Springfield: Charles C. Thomas Publications.
Bruscia, K. (1998). An introduction to music psychotherapy. In K.E. Bruscia (Ed.), *The dynamics of music psychotherapy* (pp.1-15). Gilsum, NH: Barcelona Publishers.

Bruscia, K. (2014). *Defining music therapy* (3rd ed.). University Park, IL: Barcelona Publishers.
Cage, J. (1961). *Silence: Lectures and writings.* Hanover: Wesleyan University Press.
Cage, J. (1967). *A year from Monday: New lectures and writings*. Hanover: Wesleyan University Press.
Cage, J. (1973). *M: Writings '67-'72*. Hanover: Wesleyan University Press.
Curreri, E. (2013). Aesthetic perturbation: Using a chance/ aleatoric music therapy intervention to reduce rigidity in adult patients with psychiatric disorders. *Music Therapy Perspectives, 31*(2), 105–111. https://doi.org/10.1093/mtp/31.2.105
Curreri, E. (2015). An unguided music therapy listening experience of Luigi Nono's Fragmente-Stille, an Diotima: A case report. *Music Therapy Perspectives*, *33*(1), 63-70. https://doi.org/10.1093/mtp/miu047
Duckworth, W. (1995). *Talking music: Conversations with John Cage, Philip Glass, Laurie Anderson, and five generations of American experimental composers*. New York: Schirmer Books.
Gardstrom, S. C. (2007). *Music therapy improvisation for groups: Essential leadership competencies.* Gilsum, NH: Barcelona Publishers.
Gottschalk, J. (2016). *Experimental music since 1970*. New York: Bloomsbury Academic.
Hicks, M., & Asplund, C. (2012). *Christian Wolff*. Chicago: University of Illinois Press.
Holmes, T. (2015). *Electronic and experimental music: Technology, music, and culture* (5th ed.). New York: Routledge.
Kostelanetz, R. (1989). *Conversing with Cage.* New York: Limelight Editions.
Kostelanetz, R. (1996). *John Cage (ex)plain(ed)*. New York: Schirmer Books.
Lee, C. A. (2003). *The architecture of aesthetic music therapy*. Gilsum, NH: Barcelona Publishers.
Lucier, A. (2012). *Music 109: Notes on experimental music*. Middletown, CT: Wesleyan University Press.
Nordoff, P. & Robbins, C. (2007). *Creative music therapy: A guide to fostering clinical musicianship.* Gilsum, NH: Barcelona Publishers.
Nyman, M. (1974). *Experimental music: Cage and beyond*. London: Studio Vista.
Priestley, M. (1994). *Essays on analytical music therapy.* Gilsum: NH: Barcelona Publishers.
Retallack, J. (1996). *Musicage: Cage muses on words, art, music: John Cage in conversation with Joan Retallack*. Hanover: Wesleyan University Press.
Revill, D. (1992). *The roaring silence: John Cage: A life*. New York: Arcade Publishing.
Rutherford-Johnson, T. (2017). *Music after the fall: Modern composition and culture since 1989.* Oakland, CA: University of California Press.
Wigram, T. (2004). *Improvisation: methods and techniques for music therapy clinicians, educators and students*. London: Jessica Kingsley Publishers.
Wolff, C. (1994). A short graph of intersecting statements by and about Christian Wolff. In *Christian Wolff: For Ruth Crawford* (p.2) [CD liner notes]. Switzerland: Hat Hut Records LTD.

Ελληνική περίληψη | Greek abstract

Ποιος φοβάται τον Christian Wolff? Διερευνώντας την χρήση πειραματικής μουσικής σε μια ψυχιατρική μονάδα οξείας νοσηλείας για εφήβους

Enrico Curreri

ΠΕΡΙΛΗΨΗ

Σε αυτό το άρθρο που βασίζεται στην πρακτική, ο συγγραφέας συνοψίζει το πώς μελέτησε τη χρήση πειραματικής μουσικής με εφήβους ασθενείς με καλλιτεχνικές ανησυχίες αποσκοπώντας στη βελτίωση των διαπροσωπικών σχέσεων, της συγκράτησης των παρορμήσεων, της συμμόρφωσης και της ανάγκης για διατήρηση της προσοχής. Επηρεασμένος από την πειραματική κλασσική μουσική του Αμερικανού συνθέτη Christian Wolff, ο συγγραφέας δημιούργησε μία πρωτότυπη σύνθεση πειραματικής μουσικής με τίτλο *Burdock Variations and Other Wolff*, με στόχο την εκ νέου ανα-δημιουργία της σε πλαίσια ομαδικής μουσικοθεραπείας σε μια ψυχιατρική μονάδα οξείας νοσηλείας. Απροσδόκητα, τα αποτελέσματα από την εμπειρία της πειραματικής μουσικής στην ομαδική μουσικοθεραπεία έδειξαν ότι (α) ενώ οι ανάγκες και η ανάπτυξη σχετικά με την αισθητική δεν ήταν μέρος των θεραπευτικών στόχων των ασθενών, η εμπειρία της πειραματικής μουσικής έπαιξε σημαντικό ρόλο στην καλλιέργεια, στη διαμόρφωση και στην ικανοποίηση των *αισθητικών αναγκών* του κάθε ασθενή εντός ενός ασφαλούς θεραπευτικού περιβάλλοντος, (β) προκαλώντας το *αισθητικό σύστημα* (Curreri, 2013) των εφήβων μέσα από την από κοινού διερεύνηση νέων και ασυνήθιστων ηχητικών πρακτικών, η θεραπευτική σχέση, που αναπτύσσονταν ήδη στα πλαίσια πιο τυπικών παρεμβάσεων μουσικής και δημιουργικών τεχνών, εμβαθύνθηκε περαιτέρω μεταξύ των εφήβων και του συγγραφέα, (γ) η διερεύνηση της σύνθεσης *Burdock Variations and Other Wolff* αποτελεί μία *προχωρημένη* μουσικοθεραπευτική παρέμβαση που μπορεί να εισαχθεί μετά από την διερεύνηση πιο

τυπικών μουσικοθεραπευτικών παρεμβάσεων, και (δ) η διερεύνηση της σύνθεσης *Burdock Variations and Other Wolff* μπορεί να εισαχθεί μόνο σε εφήβους ασθενείς που μπορούν να διατηρήσουν την συγκέντρωση, την περιέργεια και την προσοχή τους.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

έφηβοι, ψυχιατρική μονάδα οξείας νοσηλείας, πειραματική μουσική, Christian Wolff, ανα-δημιουργική εμπειρία, αισθητική

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INTERVIEW

A conversation about *Music and Autism: Speaking for Ourselves*

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ABSTRACT

In this conversation, music therapist Kenneth Aigen interviews ethnomusicologist Michael Bakan on the subject of Bakan's recent book, *Music and Autism: Speaking for Ourselves*. Numerous topics and issues are addressed, from autistic self-advocacy and neurodiversity to comparative considerations of music therapy-based vs. ethnomusicological approaches to engaging with autistic people through music. In the course of the dialogue, Bakan chronicles the various stages of his work in this area, from the Music-Play Project, to the Artism Ensemble, to the "Speaking for Ourselves" book project. Unifying all of this work has been a consistent emphasis on endeavouring to understand people on their own terms—as experts at being who they are—rather than on trying to change people through therapeutic interventions. This perspective is ultimately revealed as both a fundamental distinction and a powerful point of convergence between ethnomusicological and music therapy-centred approaches.

KEYWORDS

ethnomusicology,
neurodiversity,
Artism Ensemble,
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Kenneth Aigen: Michael, before we talk about your recent book, can you provide some background for our readers? You're an ethnomusicologist with a history of working with autistic folks. What were the origins of that interest? And what forms did it take?

Michael Bakan: Well, the origins of that interest go back to about 2003, when a young member of my family, "Mark," was diagnosed with an autism spectrum condition. Suddenly, autism, which I knew

very little about at the time, became a central part of my life. The pivotal moment occurred during a post-dinner drum jam session with my then-new Florida State University (FSU) ethnomusicology colleague Benjamin Koen. Ben and I were playing together. My eyes were shut. Then I felt a light tap on my leg and when I opened my eyes, Mark was sitting on the floor looking up at me. There was a pair of bongo drums beside him, and it appeared that he was asking my permission to play with us. I nodded and smiled, and he joined right in, and it turned into this kind of cathartic experience.

Anyhow, that was the spark: I realised that I had to find some way to capture that lightning in a bottle, to use the skills and training I brought to the table as a musician and ethnomusicologist to recreate that experience of our drumming together, specifically for the benefit of other kids on the spectrum, of other families. But where to begin? With Google, of course. So, I started Googling in keywords – autism, ethnomusicology, music therapy – and one name kept coming up, yours: Kenneth Aigen! I don't know if you remember this, Ken, but I just cold-called you one day back in 2003 at NYU [New York University] and, amazingly, you answered the phone. We had a great, long conversation, which really helped me to define the potential points of intersection between ethnomusicology and music therapy vis-à-vis autism, and that proved pivotal in launching the various projects in which I've been involved ever since: first the Music-Play Project from 2005-2009, then the Artism Ensemble from 2011-2013—which was supported for those three years by grants from the [US] National Endowment for the Arts—and most recently the "Speaking for Ourselves" project, which gave rise to the book we're talking about here. I should note for our readers that this book was first published in 2018 by Oxford University Press (OUP) with the title *Speaking for Ourselves: Conversations on Life, Music, and Autism*, but that OUP is releasing it again this fall [October 1, 2020] in a paperback version with a new title, *Music and Autism: Speaking for Ourselves* (Bakan, 2020). I'm very excited about that. So, a belated thank you for your help with everything, Ken. *[laughter]*

Kenneth: Sure.

Michael: Seriously, though, that phone call was a big moment for me. After that, Ben Koen and I got to work developing what would ultimately become the Music-Play Project, or MPP. We received a small, in-house grant from FSU for the pilot study in the summer of 2005 and recruited an interdisciplinary team of research collaborators comprising faculty and graduate students from across the university, including a paediatrician at the medical school, a cognitive psychologist, and the eminent autism researcher Amy Wetherby.

Working with the SCERTS (Social Communication, Emotional Regulation, and Transactional Support) Model for autism assessment developed by Wetherby, Barry Prizant, and their colleagues (Prizant et al., 2006) as the basis of our study, we used coding of video recordings of the participating children in the project to measure targeted social-emotional growth indicators. The videos followed the individual children (three or four per play group) as they navigated the free-play, improvisatory environment of a specially designed E-WoMP, or Exploratory World Music Playground. Ben and I were the designated music-play facilitators, responding through our improvisational activities in the E-WoMP to child-directed musical/social leads. The parents of the children, or in a couple of cases other caregivers, were active music players in the group as well; that

was really important. Our measures yielded both ethnographic and statistical data, and there was convergence of those streams to some extent, especially in demonstrating gains in the children's expressions of success and confidence (Bakan, 2009). So this went on for several years and it was rewarding and revealing work, but there was an increasing pull toward quantification and assessment, toward converting this musical, playful, spontaneous enterprise into something that would yield outcomes suited to publications in scientific journals, to securing grants from scientific research-funding organisations, all that kind of stuff. And the more "scienceward" the project went, the more the soul of what I had originally conceived for it seemed to be slipping away.

I became increasingly unhappy with the direction things were going, and so, in 2010, I just, well, stepped away from it all. By that time, there was a series of publications issuing from the work, and we had done some good in the world, I imagined (see Bakan et al., 2008; Bakan, 2009). Meanwhile, Ben had upped and moved to China to take a university teaching position there. It seemed like a good time for a new life chapter, and I figured that was pretty much that. But a couple of months later, quite out of the blue, I was contacted by the Florida Division of Arts and Culture in the Department of State. They were launching a new, joint programme with the National Endowment for the Arts aimed at developing innovative programmes to serve underrepresented populations in the state of Florida. They were familiar with my music and autism work and asked whether I might consider submitting a grant proposal in that area. So I thought to myself, 'Well, okay, we're talking arts here, we're talking culture. These are my comfort zones, my familiar places. This sounds good!' I wrote the grant and it was successful, and that's how the Artism Ensemble was born.

Artism certainly had its roots in the Music-Play Project concept, but it was a boldly different kind of undertaking. Over the three years of the group's life (2011-2013), there were either four or five children on the spectrum in the group at any one time; all were "graduates" of the Music-Play Project who had thrived in that environment. As before, parent involvement as active music players was essential. As for the music-play facilitators, rather than just having two, as we had in MPP (Ben and me), there were now six or seven professional musicians/ethnomusicologists from countries—and representing musical traditions—all over the world: China, Bolivia, Trinidad, the U.S., etc. All of them had in their various ways found their way to Tallahassee, most as graduate students in the ethnomusicology programme at FSU. But there were a couple of music therapy students involved, too, and even a professor from down the road at Florida Agricultural and Mechanical University (FAMU): the great jazz bassist Brian Hall. And right from the start, this was not a play-lab kind of deal but a real performing *band*, which was designed to go out and play public concerts and do other outreach events to promote autism acceptance throughout the state and beyond. The idea was not to "measure" or provide "interventions" for autistic kids – quite the opposite. Our mission was to put a different public face on autism, to compel our neurotypical-dominated audiences to see this neurodiverse, intergenerational group of adults and kids, musicians and "non-musicians," autistic people and non-autistic people, sharing social and musical space with creativity, humour, compassion, and a sense of advocacy, an advocacy born of a desire to *force* the world to see and appreciate the essential humanity and sociality of autistic people.

Artism was thriving, and then came what appeared to be the capstone event of our musicultural journey to date: a featured performance at the opening general session of the international conference of the Society for Disability Studies in 2013, which took place in Orlando,

Florida. That was the furthest our group had ever travelled—our events to that point had all been in Tallahassee or close by—and it was a major undertaking to get the whole show on the road, as you can surely imagine. But we pulled it off and it seemed like a great success – standing ovations, lots of praise, the whole nine yards. And then, crisis. The rest of the group returned to Tallahassee the day after the show but I stayed in Orlando to attend the rest of the conference. A couple of days in, I attended a roundtable organised by Elizabeth J. Grace, aka Ibby Grace, and a panel of her fellow autistic self-advocates. The final hour was dedicated to open discussion and a question-and-answer session. To this point, I had never had the opportunity to get significant feedback on Artism from a cohort of autistic adults, let alone autistic adults actively involved in neurodiversity studies and advocacy initiatives like these folks clearly were. I was eager to get their perspective. So, I raised my hand and asked a question: 'Were any of you at the Artism Ensemble concert the other night? What were your impressions of it?' One member of the panel literally jumped to the centre of the room and told me that he had found the concert "offensive." He then proceeded to lay out a thoroughgoing critique: 'Why were there only autistic children and non-autistic adults in the group?' he complained. 'That reinforced mythologies of autism as a "children's disease," and it deprived the kids of positive, adult autistic role models as well. Why the use of percussion instruments that could be disturbing to autistic people (like himself) with hyper-sensitivity to loud sounds?' he continued. And most importantly, he asked me why the reviled phrase "autism awareness" appeared on the NEA evaluation questionnaire I had prepared and distributed to the audience? Was I a "plant" from Autism Speaks sent to infiltrate this safe-space meeting?

Wow! This was not what I was expecting, I can tell you that. Thankfully, I did manage to keep my cool, though my heart was racing and I was sweating profusely. It was pretty intense, really stressful. When he was done, I took a deep breath and did my best to give a measured response. I explained that I was very sorry, that I wanted to learn, that I was committed to doing better. And Ibby Grace, in that beautiful, calm Ibby Grace way she has about her, brought all the tension down to calm. "We can help you with all that," she said reassuringly, and afterward she gave me her card, and I contacted her, and, to make a very long story short, that was the *next* big moment in this whole odyssey, the one that would shift me from Artism toward the "Speaking for Ourselves" project, and eventually the new book. Ibby is one of my ten co-authors on that project, I'm proud to say. All ten of them, despite their immense diversity on other levels, basically share two things in common: an autism spectrum diagnosis and a life in which music plays a major role, whether they are musicians per se (as several are) or not (as several are as well).

Kenneth: For folks who we want to interest in reading your book, you describe that experience, of being taken to task at the Society for Disability Studies conference, in the chapter you co-wrote with Ibby Grace, and I'd like all the therapists out there to know that you really approach the whole topic with a high degree of reflexivity and self-critique. I think therapists, part of whose training is to engage in those processes, will find your ability to speak with candour and to look at your interactions critically very engaging and refreshing.

Michael: Thanks. I appreciate that. I mean, I really felt that there was no choice in the matter. These were people speaking from the inside of the autistic self-advocacy world. They had a valid set of

criticisms. And what sparked the whole fiasco was that reference to "autism awareness" in the NEA questionnaire that I mentioned earlier. It had not even occurred to me that this might be inflammatory. The question read something like this: In terms of promoting autism awareness, this concert was (a) Excellent, (b) Very good, (c) Satisfactory – and so on. Pretty benign stuff, or so it seemed, but it turns out that "autism awareness" is a phrase you did not want to be bandying about with people in the autistic self-advocacy community at that time, because it's closely associated with the Autism Speaks organisation, which they felt had been involved historically in a lot of the wrong kinds of priorities—research on prenatal detection, efforts to "cure" autism, remediation and intervention programmes—whereas autistic people in the community that I'm speaking to are saying, 'We are who we are. We're fine the way we are, being who we are, and what we mainly want is *acceptance*. We don't want awareness. We want to be accepted for who we are, as we are.' As an ethnographer, an ethnomusicologist, honouring that desire, that initiative, makes the greatest sense in the world to me, so I owe people like Ibby, and Amy Sequenzia, and all of my other *Music and Autism* co-authors—among other folks with whom I've worked and played music—a tremendous debt of gratitude for calling me out and helping me to see better paths forward.

Kenneth: Right. And in the current climate, using that phrase, autism awareness, is akin to saying that we're increasing "racism awareness," and with that not being nearly enough at this point. I think people want change, not just awareness, of a problem.

Michael: That's right. I think the analogies between the heated response I got at that time, which quite honestly really blew me out of the water, and what we're seeing right now around a lot of issues affecting people who have historically been disenfranchised, marginalised, and suppressed, are spot-on. These different communities are each engaged in their unique situations, but they also share a great deal in terms of the types of common struggles they have faced, and continue to face. In joining voices with my autistic co-authors in the book, I hope we are contributing something of real value to these larger conversations at this critical, precarious historical moment.

Kenneth: The "Speaking for Ourselves" portion of the title suggests the idea that disability rights are civil rights. Is this interpretation correct and does it align with your intentions for the book?

Michael: Yes, that's right. The idea of "speaking for ourselves" is key to the sociopolitical mission of the book, in that if there's one thing that needs to be addressed right now in the realm of autism—in autistic lives, in autistic discourses, in public policy—it's that people from within the autistic community are motivated to speak on their own behalf, are capable of speaking on their own behalf, and need to be *heard* speaking on their own behalf. And it's not just a matter of being heard either. They need to be really *listened* to—carefully, thoroughly, compassionately—because they bring to the conversation an awful lot of knowledge and insight and understanding, of forms and ways of knowing that, quite simply, no one else can possess, let alone convey. It's the same conversation that's going on around race right now, where you or I, as white people, and as white men in particular, it doesn't matter how much we read or align or engage in productive forms of activism. There's still a fundamental level at which we can *never* fully understand the experience of being Black in the United

States. We need to accept that, and we need to really listen to people who know what they're talking about, on that deep, experiential, existential level. The exact same rule applies with autistic people, and that is a key point of the book.

Kenneth: Maybe just a word on the process of the book. Even though most of your co-authors, I think all except one, seemed to be adept at spoken, oral communication, you opted to engage in dialogue through text-based messaging. I was wondering why you made that choice and how you think it influenced the nature of the interactions and the content that you received.

Michael: That's a great question. I'd like to say that it was all carefully planned out ahead of time, but, as is the case with most ethnography and field-research-based work, a lot of what happened was happenstance. The first two chapters are actually based on face-to-face conversations, and those conversations were with two girls—now young women—who were members of the Artism Ensemble. In those chapters, then, we were essentially recreating those dialogues. All of the rest of the chapters, however, stem from texting-based, typing-generated, online dialogues, most of which took place using the Google Hangouts platform.

Where that format began was with my co-author in Chapter 4, who goes by the pseudonym Donald Rindale. Donald was living in Boston when he first contacted me via email. At the time, he was finishing up a master's degree in musicology up that way, but he was interested in transferring to FSU for his doctoral studies. Part of the motivation was to work with me. He had seen a TED Talk I had presented (Bakan, 2012), which had inspired him to combine his musicological interests as someone on the spectrum with an interest in issues of autism and autistic representation.

I told Donald I'd be happy to speak with him about the FSU graduate musicology programme and we set up a meeting, but I also took the opportunity to ask him if he would consider being interviewed for a book I was working on, since, as a musician and musicologist on the spectrum, he seemed like a perfect "candidate." He was excited to be part of the project, but I didn't have any kind of grant to go flying up to Boston or to fly him down to Tallahassee, so we looked at what our options might be and decided that the texting-based Google Hangouts approach would be a good way to go for a couple of reasons. First, Donald was very comfortable with the idea of our using typing as our main mode of communication, and, as I was to discover, many autistic people actually feel *more* comfortable with that mode of interaction than with speaking, face-to-face-type communication, because it takes away the eye-contact pressures and the social pressures—you know, 'I can't stim because people are watching me.' So that was one plus for the texting approach.

Another—and in all honesty this one spoke to my own selfish interests in the enterprise—was that Google Hangouts generated a transcript of the whole texting-based conversation *instantly*, with no need for tedious transcribing, no worrying about 'Wait, did I hear what he said correctly?' Plus, with that complete transcript in hand right from the get-go, we could go back and do dialogic editing as much as we wanted to, so we could both be looking at the original transcript and he could say, 'Well, that's not really quite what I wanted to say,' and then we could go in and make tweaks. It was a real revelation, actually a real liberation!

So we did the first interview using this Google Hangouts typing/texting format and it went great. And after we were done, I pulled up the transcript and started to read it, and then I started to

panic. Donald wrote so lucidly, so brilliantly, that it was essentially a finished product, ready for prime time. It was like looking at those original Mozart manuscripts where there are no cross-outs, no edits; everything's just as it should be right out of the gate. So then I'm freaking out, you know, 'But wait a sec, I'm an ethnographer. I'm supposed to be taking the words of the people that I collaborate with and shaping them into narratives, contextualising them relative to my own interpretive frames,' all that stuff. But there was none of that to do because Donald had already articulated his thoughts and ideas so perfectly, so eloquently. The guy's basically a genius; he's already interpreted *himself*. And I'm thinking 'There's really no job for me to do here,' and that was disheartening.

But then I had this flash of insight. I thought, well, if I'm not going to represent Donald in this book, then I will *re-present* him instead. And that became the theoretical hub of the whole project, this move away from representation toward re-presentation. The conversations that went down *are* the ethnography, not the basis of the ethnography. The interpretation, the analysis, all of that – it's in the conversations themselves, and the book is a collection of conversations first and foremost. Yes, I'm there in a kind of narrator's role – '"Blah blah blah," Donald exclaimed; "Blah blah blah blah," I replied, stroking my beard in contemplation…' – but that's kind of the long and the short of it. I try to stay out of the way as much as possible (other than through my presence as my co-authors' main partner in dialogue, which is, granted, significant), to let the *conversations* speak for themselves, so that brings us back to the title again, I guess.

Kenneth: Well, okay, but you also share some of your thoughts in those conversations, which sometimes take the form of self-critique: reflecting critically on the questions you were asking, or on the ways you had misinterpreted things your interlocutors were telling you, or how you had pushed the conversation in a counterproductive direction. It's more than just the dialogue.

Michael: Yes, that's right, that's true. I guess what I'm trying to get at here is the idea that the interpretation—to the extent that I'm making interpretations, or that I'm making inferences about things that are going on "between the lines" of what the other person is saying *in* the conversation—is essentially built *into* the conversation, as opposed to being extracted out of the conversation. There isn't this kind of, 'Well, here's the dialogue transcript, now let me tell you what's *really* going on.' And that makes me feel comfortable, at least relatively so, with the "speaking for ourselves" tag. I feel that my role in this book is less that of an author per se than, say, that of the producer of a film.

Kenneth: Right. You are one of the people in the book speaking for *your*self, but you've also given the participants an opportunity to speak for themselves. You're not speaking for them. And their voices aren't mediated through your concepts and interpretations, and that's one of the real benefits of that approach.

Michael: Well said, and I'll let you speak for yourself on that! *[laughter]*

Kenneth: I'd like to get into some specific questions. Again, we have a readership of music therapists and other music and health professionals, and I've got some things to ask you about that I think

might be of particular interest. A few of the participants [in your project] talked about how they can engage in levels and types of social interaction in musical situations that would be much more challenging outside of music. Do you have any thoughts to share on what is it about musical engagement and interaction that afforded this sort of difference in functioning level or difference in interactive capacities?

Michael: As a kind of preface to my response to that question, one thing that comes through in the individual chapters is how incredibly diverse this group of ten people is. Yes, they all share an abiding passion, of some kind or another, for music, and they all share the fact of an autism spectrum diagnosis. But beyond that, it's all over the map as far as how they're interacting with music, with people, and basically everything else. So, there's no one answer to that question. The best way for me to respond would be with a couple of specific examples. If we look at Chapter 3—the Mara Chasar chapter—she was a seven-year-old girl when we started playing music together in the Music-Play Project, and then we continued collaborating through various later projects. In fact, we have a new, co-authored chapter coming out soon; it will be in the forthcoming Oxford Handbook on early childhood music learning and development, and Mara, who is now nineteen, is first author!

Mara has actually had had some very *negative* experiences with music outside of our projects, because of the specific kinds of expectations and demands that those other musical experiences imposed on her. A prime example was her high school choir, where she was required to wear tight and uncomfortable dresses, perform with no freedom of movement at all, and be in total conformity with her fellow singers pretty much all the time. She found that all to be incredibly oppressive, even traumatic. She claims that what made Artism so different—and so vastly preferable—was that there were no predefined expectations in terms of outcomes. The music didn't have to come out sounding any way in particular, and where it was going to end up was mainly up to the kid in the group—Mara or one of the others at any given moment—whose turn it was in that moment to be in charge, to be the director, the composer, the lead performer. Artism's creative process, its *social* process, was always a process of becoming, and being in a space where there were by definition no wrong notes, no wrong ways of being or doing (so long as no one was getting hurt or disrespected), was really liberating, not just for Mara and the other children in the band, but for the parents and the professional musicians, too.

That E-WoMP was a really special place, not perfect, but definitely special. I think it provided a model of a type of musicultural environment that many music therapists could benefit from knowing about. I encourage everyone who does this kind of work to consider the possibility of engaging musically with people on the spectrum (actually with all kinds of people) through methods that don't predetermine *any* specific repertoire or desired musical outcome. Think of it as 'We're having a conversation; it might go here, it might go there, and we're going to simply try to follow each other's flow, damned be the consequences.' It's not an easy thing to do. It can actually be pretty terrifying—and it's definitely tough on the ego if you're the type who prides themselves on high "performance standards" when on stage—but the rewards can be great if you just allow yourself to yield and give in to the process. Easier said than done, though.

Kenneth: The next question I have is complementary to what you've outlined. I don't want to reframe

what you're saying from the music therapist's point of view; however, what you discovered in your work is basically a tenet of what we call "music-centered music therapy" (Aigen, 2005), which is really an outlier in the field, the idea being that you actually get better non-musical outcomes when you're not playing music to change somebody. You get increased social and emotional benefits when you're not trying to force that, when you're fully engaging the person in the music. It seems like you empirically discovered the benefits of this music-centered approach. Not that this approach is not problematic in its own right. It goes against the conventional wisdom in music therapy, which is that music therapy is the use of music to achieve a non-musical goal. This definition of music therapy is not accurate for music-centered approaches. Sometimes we see benefits in non-musical areas, but they come about because the person was fully engaged in the music. That seems to be what you did coming in with your ethnomusicological approach: 'We're here to play music with people, not to change them.'

Michael: Precisely, and allow me to build on that idea through a couple of different examples. Here's the first one. When I'm in the E-WoMP, I'm a musician and an ethnomusicologist, which is exactly what I was many years ago as well while doing intensive ethnomusicological fieldwork with gamelan beleganjur musicians in Bali, Indonesia (Bakan, 1999). When I went to Bali, I went there with the assumption that my job, first and foremost, was to try to understand this Balinese musical system and its cultural world, and to do so, at least as well as I could, in the ways that the people who lived in that world understood and experienced it themselves. I went in with an attitude of 'I'm here to observe. If they invite me to participate, then I'll do that, too.' Later on, I would be able to step away, to look back at my notes, reflect on my experiences, analyse my video recordings, and hopefully come away with some insights into how and why these Balinese people I had come to know were musical people, how they were experts at being who they are, and how their being musical was a part of what *made* them Balinese, and vice-versa.

And that's pretty much the whole deal. There's no sense in me going in and saying, 'Okay, I see what you're doing, and it's all very good, but you might consider having a conductor lead the gamelan rather than the drummer; that would be more efficient. Oh, and you also might want to rethink the tuning of your instruments. Don't you think A440 would be a better way to go here, rather than this odd, male-female paired-tuning *ombak* thing you do?' *[Kenneth laughs]*

You're laughing at the absurdity of the prospect of an ethnomusicologist even thinking such thoughts, let alone acting on them. Yet, when I tell people about my work with autistic people, they're immediately like, 'Oh, what problems are you addressing? What interventions are you using? What are the outcomes and improvements you're seeing?' Trust me, nobody asks me those questions about my gamelan research.

But to me it should be exactly the same. It's not about changing people, let alone "improving" them. It's about understanding people. When I go into the E-WoMP, I'm playing music and I'm being an ethnomusicologist, just like in Bali. I'm in the E-WoMP to observe what the people who are the insiders of this music culture, these being the autistic members of the group, are doing, and how and why they are doing it. What makes them tick? How are they defining their own identities and interactions within the space? How do *they* manifest the reality of their being experts at being who they are? If I'm fortunate enough, they'll invite me to participate in that musicultural word with them.

And then, afterwards, hopefully I can step back out and come up with something meaningful and true that I can "translate" and then share with other people. That ethnomusicological method is absolutely what I'm applying. There's no desired outcome other than to understand. To understand, we observe, we listen, we participate. Then we try to interpret or try to re-present (as opposed to represent).

My second example takes us back to the early days of the Music-Play Project, circa 2005 or 2006. There was this one kid ("Frank" in the 2008 *Ethnomusicology* article "Following Frank…"; see Bakan et al., 2008) who was quite destructive. He would knock down the instruments, hit himself or others with mallets (fortunately they were made of soft rubber), all kinds of stuff. But then he was usually able to calm himself down and get back in sync. In the moment, I never knew what accounted for those transitions, but months later, in analysing the documentary videos of his sessions, I discovered that he had developed a real method for his emotional self-regulation. When he was dysregulated, he would quite consistently do one of two things: either go wrap himself around Ben Koen's didgeridoo while Ben was playing it, or else go sit in front of the largest gong of the gamelan (sessions at that time were held in the FSU gamelan room) and strike it repeatedly. And whenever he used these methods, you could literally see the tension, frustration, and anger melting away and being replaced by relative calmness. I deduced that this had to do with the low frequencies and strong vibrations of these instruments, that this kid was using a kind of low-frequency, somatic therapy on himself.

So, this was a big breakthrough for me. I was all excited, and I rushed home from the video analysis lab to tell my wife, Megan (a cognitive psychologist who at the time was a collaborator on the project), about my discovery. I stormed into the kitchen and started babbling on about my 'eureka moment' and the apparent therapeutic effects of low-frequency tones on emotional dysregulation in autism, yada yada.

And Megan just cut me off, full stop, and she was like, 'You just don't get it, do you, Michael? You're always all about what's going on in the music and the vibrations and the this and that. That's all fine and good, but what's *really* happening there is that you're walking into this room with these kids and their parents, and the kids, who are always being measured as coming up short, whether it's on the soccer field or in a piano lesson or at school, they're getting to succeed instead. You're closing the door and you're creating a safe space where they can just *play*, without any expectation of what that's going to produce, what the music is going to sound like; and as long as they're not hurting each other or breaking things, they're basically free to do what they want. That freedom for those kids, and also the chance their parents get to play with them in this safe, non-judgmental place—and where they get to see their children succeeding for a change, because they're not being evaluated in terms of "measures of success"—that's where the magic happens.'

And you know what, I've got to admit that Megan was right (though I still think there's something to my low-frequency/emotional regulation theory, truth be told). The idea is that the experience *is* the method, with participation itself being the outcome, and also the measure of success.

Kenneth: That's right. Success is participating.

Michael: And that success can involve participating in a seemingly non-participatory way as well.

Kenneth: Right, even if it's listening, it's participating. It's being in the sound environment. In music therapy, receptive methods that utilise music listening are not passive but can be considered an active method because the participant's mind is actively engaged. So, let me ask you about another of your collaborators on the book, Ibby Grace, your Chapter 5 co-author and conversational partner. Some of the participants in the project talked about social participation, while others talked about how, through music, they could gain insight into the inner worlds of other people, how they had developed an enhanced capacity for what psychotherapists call intersubjectivity. Ibby, in particular, talked about how she hears people as music. In some forms of music therapy, this ability to create a portrait in sound of the inner person is an important skill. Drawing from the conversations in the book, can you speak a little bit to how it seemed that for some autistic folks, music was a medium which allowed them to understand other beings as having inner worlds that somehow they could get inside of? The other aspect of that had to do with their ideas about how they understood emotions through music, about how verbal language may have been opaque in terms of how words related to feelings, whereas somehow in music this ability to feel the universality of human experience was enhanced.

Michael: Yes, great. There's a lot in that question! Let's start with Ibby. She talks about a couple of different things. One is this idea that she "thinks in music" in the same way that Temple Grandin "thinks in pictures" (Grandin, 2006). It's just a different kind of cognitive process than we're normally expected to rely on, given the profusely language-centred society in which we live. Our social institutions, our educational systems, our professional structures are all generated around these ideas that the lowest common denominator is language. If we can't language it, then it can't really be. It's empirically not present. Now, Ibby works in logic, so she's actually a very sophisticated thinker in those languaging ways. But as she says of herself in the chapter, "I suck at languaging feelings." By her own account, thinking musically enables Ibby to bypass the strictures of language. She can thereby connect the sonic, embodied experience of music to her own feelings, as well as to her perceptions of the feelings of others.

Where I think this becomes especially important as a therapeutic modality, and also in terms of the importance of what we were talking about earlier, is that we really need to listen to what autistic people are saying about what matters, what they need, how to proceed with all of this work. Ibby claims, and I have no reason to not believe her claim, that she hears people *as* music, that she actually experiences people as music. So when she meets two people, she gets a sense of how they will likely interact "harmonically" with one another, and from that she can deduce whether or not they are likely to get along. One of the big problems that we have in this area of work is that because books are things of words—because communication in the neurotypical world generally is premised on words, in fact—we end up greatly privileging the communications of autistic people who speak over those who do not in publications (though *all* autistic voices have been marginalised historically, but I digress). And among those who do not speak, those who at least have other means of communication (such as typed language) have a distinct advantage over those who do not. That would be the case, for example, with the well-known author, autistic self-advocate, and social activist

Amy Sequenzia, my Chapter 10 co-author.

But there are so many autistic folks who do not speak, and who have not yet found effective ways of communicating their thoughts and ideas to others in ways that are understood. Ibby's thinking-in-music process holds real potential for bridging the gap. Through that process, her process of perceiving people as music, she asserts that she is often able to understand and interpret what non-speaking autistic people are saying, and I absolutely believe that this is indeed the case. So, there's a kind of empathy across the continuum of the autism spectrum that gives Ibby this capacity to connect, to on some level represent and re-present the unspoken thoughts and ideas of non-speaking autistic people, which would otherwise be unavailable to the rest of us who don't (yet) possess her skills of perception. Now, I realise that this is controversial. It's problematic. It can all be challenged. But I am convinced beyond the shadow of a doubt that it is all profoundly real, and that Ibby brings true credibility to the claims she makes.

Kenneth: It's actually very similar to what happens in Nordoff-Robbins music therapy, where the idea is that you let yourself resonate to something unseen in the person, or maybe it's to body language or facial expression, and you put that into sound. You play it and it engages the person; it validates your impression that whatever sound you're creating is some sort of a reflection or representation of that inner being.

Michael: And that's applied, empirical research.

Kenneth: Right, so it's saying use your intuition, and if it seems mystical or esoteric, that's only the source. It's validated by whether it works to engage the person. So, to me, that's what warrants it in a professional, clinical domain.

Michael: What would be really wonderful in a clinical context like Nordoff-Robbins, I think, would be to have an autistic facilitator, someone like Ibby, with her special skills of intersubjectivity and empathy, be an integral part of the clinical team when working, say, with a non-speaking autistic client. That could be a quantum leap, building from that intuitive response of a skilled therapist, like yourself, toward some kind of empirical validation from an autistic consultant, like Ibby. These kinds of possibilities are so exciting, when we can envision—and ultimately bring to fruition as well, hopefully—synergistic modes of collaboration across intersecting communities of neurodiversity and interdisciplinarity: music therapy, autistic self-advocacy, ethnomusicology. Wow, we could do some great work!

Kenneth: You know that I'm doing a similar project to yours now called "Music in Everyday Autistic Life." It is a project being funded by the American Music Therapy Association (AMTA) and it demonstrates how mainstream thinking in music therapy has come around to understanding the importance of including neurodiverse perspectives in research. I'm doing this project a little differently from how you did yours, more as a traditional, bounded, social science research study with two neurodiverse people on the research team. I've had about five or six conversations so far. Something that's come up, that a few of my interlocutors have highlighted, is how, when they

experience sensory meltdown, they might turn to music. It may seem counterintuitive for them to increase sensory stimulation when they're feeling overwhelmed on a sensory level, but what they say is that the music actually functions to give them a sense of control so they can manage the meltdown, maybe even at times deliberately choosing music that's going to push the meltdown further so they can move through it and come out the other end. Some of your co-authors mentioned something similar. Addison Silar, in Chapter 11, talked about how music blocks out the multiple bombardments of sensory stimulation that would otherwise make it hard for him to function. I'm wondering if you have any thoughts about music and sensory stimulation and meltdowns. One thing we're really interested in with my project is the question of how do autistic folks already use music in daily life as a health resource. You have all these music therapists deciding how to use music, but we've never talked to autistic folks about what resources they already have that we could learn from.

Michael: Ha! That reminds me of my earlier account of "Frank" in the E-WoMP with the didgeridoo and the gongs. In terms of my collaborators on the book, though, my conversations with Addison, and also with Amy Sequenzia, could be especially revealing in this arena. At the time we were working on our chapter together, Addison, then a teenager, was writing a science fiction novel called "The Unfortunate Project." Music listening was absolutely integral to his creative process. He would put on a piece of recorded music, allow it to inhabit his cognitive space, and then "translate" what he was perceiving in the music into the various aspects of his literary production: the plot, the development of characters, the relationships between the characters—basically he was channelling the music into the form of his novel. Really fascinating stuff!

Yet for Addison, music listening was a double-edged sword. It was fine as an immersive medium for writing fiction, but he got so deeply into it when he was trying to do other tasks—reading, homework, computer programming—that it often became a distraction which impeded his ability to get things done. But he kept listening when doing them nonetheless, which didn't make sense to me. I asked him why he did that. I still recall his response: "And why do I do it if it is sometimes distracting? Because it's even more distracting without."

This was a revelation for me. It actually brings to mind some of the things I learned from my research on the culture surrounding Balinese gamelan, strange as that may seem. In Balinese cosmology, you have this large range of "evil spirits" of the Lower World. They're all evil, but some more so than others, so the Balinese people of the Middle World recruit some of the less malevolent Lower World spirits to *protect* them from the really nasty ones. That's why you see evil spirit images carved onto the sides of many gamelan instruments. They're there to protect the gamelan! It's risky to align with these relatively benevolent malevolents, but it's a risk worth taking to prevent the most dire consequences. It's kind of like having a guard dog. You've got a big Rottweiler who could turn on you, but you hedge your bets that he's on your side. That's what Addison was describing. Yes, music has the power to distract and get in the way, but it can also keep at bay sources of distraction and destruction that are a lot worse.

Kenneth: Can you ride the tiger? Can you control the force? Think of cultures where psychedelic drugs, plants might be used a certain way. There's a danger there, but there's also something really positive and instructive.

Michael: Right, and you could add prescription medications to that list as well! Before we move on to your next question, let me return to the last one—about how autistic people use music as a health resource—relative to Amy Sequenzia. Amy is non-speaking, as I mentioned earlier, and she also has cerebral palsy and a range of other conditions, including seizure disorder. When we started working together on our chapter, Amy knew she liked music, but she had not yet really thought through how significant a role music played in her life. According to her, it was actually *through* our conversations for the book that she became cognizant of just how important music was to her, which was a very cool process for me to be a part of. Anyhow, one area of particular importance had to do with sensory issues. Amy's relationship with her physical body is complex. She often does not experience normal pain sensations, which can of course be dangerous (e.g., touching a hot stove). She also has problems with processing bodily functions, like knowing when she needs to go to the bathroom. Music helps her to navigate these challenges. Listening puts her quite literally in tune with her body, in ways that stimulate her abilities to experience physical pain, to know when she needs to go to the bathroom, and so on. Music listening serves as a coping mechanism. On this level, at least, there is nothing abstract about it at all.

Kenneth: It's amazing. So many things you're mentioning have parallels in different areas of music therapy practice. For example, music therapists work in pain relief and find that they can use music in a way that radically reduces people's need for pain medication, the idea being that music occupies the neural pathways that block the pain signals. That reminds me of what you're talking about with Amy. People have taken up Oliver Sacks's work a little bit to show how music can animate, how it can help motor rehabilitation by connecting people to impaired pathways or impaired limbs, how it can be effective in stroke rehabilitation. It's amazing to me how in this small subset of people, of autistic people, we're seeing so many of the generalised functions of music therapy. The concert pianist Dotan Nitzberg, your co-author in Chapter 6, talked about how he had been told his playing had a deficit of emotion, but he countered that it in fact was characterised by an overdose of emotion. This brings up a really important question. It seems to me that people often conflate how expressive a person is outwardly with what that person may be feeling inwardly. They are judging what the person is feeling. If they don't see the outward manifestation, they think they're not experiencing it inwardly. I've always felt that is a common error made by neurotypical people in trying to understand autistic individuals. In the 1970s and 1980s, I remember textbooks saying autistic kids must be unfeeling, right? I want you to speak to that in general, based on your intimate knowledge—you've gotten to know a number of autistic people in a more intimate way—and I'd also invite you to speak more about their emotional lives. If you want to reference Dotan in particular, I'd be interested in your thoughts about that issue of the conflating of feeling versus showing.

Michael: Sure. There was a point at which I had written a draft of the concluding chapter for this book that I ultimately decided to throw out, the rationale being that it was philosophically antithetical to the ambition of the project. I had tried to take all of these conversations and identify a half-dozen themes to summarise and coalesce them into a cohesive whole. In theory, that may be a great thing to do, but for this particular project, I decided it wasn't the right way to go.

But I still have the notes on all of that, and if there's one theme that came up over and over

again, in more chapters than any other, it was this theme of emotional expression and empathy. In one manner or another, every one of my ten collaborators stated something to the effect of the following: 'I experience emotion at least as deeply as your average, neurotypical person. I experience empathy at least as deeply as well. If I have any kind of problem in that department at all, it's that I experience these things too much, not too little, and that can prove debilitating in this neurotypical-dominated society in which we live.'

In the case of Dotan, this challenge manifests on at least two levels. The first level relates to what you're talking about vis-à-vis the feeling-versus-showing conundrum. Dotan's stage demeanour is different from that of your "average" concert pianist. Because he bows in a different way, because he interacts with the audience in a different way, because his facial expressions show things you wouldn't expect to see and don't show things you would expect to see, some audience members at his recitals will infer that there is something not "right" here: he can't be a *true* concert pianist, a *true* musical artist, because he doesn't look the part; he doesn't satisfy their central casting desires of what a concert pianist should "be like." Now, there are musicians who have managed to overcome those sorts of prejudices. On the one hand, you had the violinist Jascha Heifetz, who stood still as a statue, seemingly devoid of emotion altogether, when he played, but was lauded for his artistry nonetheless. Or there's Keith Jarrett…

Kenneth: The opposite.

Michael: Right, the opposite!

Kenneth: He's dancing, grunting, and moaning…

Michael: Exactly, but that became his thing, and people eventually accepted him on his own grunting-and-moaning terms. Now with a musician of Dotan's calibre, the artist that he is (and I've heard him play often – he's brilliant!), the potential for that same kind of acceptance, despite the "eccentricities," could be there as well. But there's an additional variable with which he has to contend, which is that people know he's autistic. And because they know he's autistic, they also "know," even though it's patently false, that autistic people are not emotional and are not empathetic. Therefore, it is one of those "if A+B=C, then C+D must equal E" kinds of things – no truth to it, but people believe that there is, so it doesn't matter. Clearly, they surmise, he is emotionally deficient, and *that's* why he looks the way he does when he plays, *and I can hear it*. But can they really? Almost surely not, because what they are so sure of is a fiction; there's no there there. But we convince ourselves otherwise, because that's what us neurotypicals do. That's our strategy for cognition and interpretation, right? We tell ourselves that because this person looks different and because this person is autistic, those two factors together lead to the "inevitable" conclusion that the music cannot be emotional because the person is not emotional. And that becomes crippling, debilitating; how can you win with the deck stacked against you like that, especially in a cut-throat, competitive business like the concert piano world?

This is a great example of the medical versus the social model of disability, right? The medical model is saying 'here is a particular pathology, here's what's going on'; the social model is saying 'no,

it's the environment that's creating the disability,' or the *disenabling* effect, you might say. If you are a classical pianist who is autistic and is known to be so, and who manifests that autistic-ness in ways that make it easy for people to pick on you—because that's the way you look, so that must be the way you are, and in turn the way you play—then you are immediately discriminated against, and you are ultimately pushed out. This is a form of bigotry that deprives many people of their ability to live their lives as they wish to, and to express and benefit from the talents they possess, from which they ought rightly deserve to benefit.

Kenneth: That reminds me a little of Maureen Pytlik, in Chapter 8, who talked about how her flexibility in teaching was actually a product of her Asperger's. You described this as turning another stereotype about autistic people—that they lack flexibility—on its head. It just seems like there were a lot of things about the conventional wisdom about autism that doing this project contradicted for you.

Michael: Absolutely! Conventional wisdom can be a very dangerous thing. Yes, the chapter with Maureen offers many great examples of the fallacies surrounding essentialisms associated with autistic personhood. Her explanations of how she teaches clarinet, as well as music theory, effectively debunk many common misconceptions. As a teacher, she is deeply in tune with her students; with their unique approaches and learning idiosyncrasies, their emotional and motivational challenges. She is ultra-flexible, ultra-empathetic, the opposite of what the textbooks would tell us autistic people are like. She has the patience to stay with her students through their processes and challenges. So yes, turning conventional wisdom on its head for sure. It's a case of things being exactly what we don't assume to be true, and being exactly what turns out to *be* true.

Kenneth: So, last question, Michael. The book's been out for two years now. Are there any particular reactions, particular perspectives, that you've found gratifying, surprising, difficult…anything about the reactions to the book that you'd like to share?

Michael: I've been pleasantly surprised at how positive the reaction has been, especially from within the autistic community. I think that's no credit to me in particular, though; it's just that the people I had the honour of collaborating with were so darned eloquent, intelligent, and insightful. It's their book. Hopefully I did a decent enough job of not stepping on their toes in the dialogues; of amplifying their voices through the construction of a narrative that does their thoughts, ideas, and passions justice; and of bringing attention to the very important things they have to say in the context of a publication that has the potential to reach readers and audiences that they might not have reached otherwise. I'm excited that the book is now being released in paperback, and with a new design that puts the names of all of my co-authors on the front cover where they belong. I fought hard for that design change and I'm really thankful to Oxford University Press for honouring my request!

Kenneth: I'll just sum up for our music therapy readership that what you did was you engaged with these people, with these representatives of a culture, to be understood on their own terms, not as a people or a group of people who are broken and who need to be fixed or changed. I think that's where

the world is moving to in terms of understanding autism. Just like forty years ago, if you were gay and got a diagnosis, that was a reason to be in therapy. Likewise, it used to be—and still often is—that because you were autistic, that was a reason to be in therapy. We're moving beyond that formulation, and your book represents that very impressive development. I want to encourage all readers of the journal to get it in its latest version.

Michael: Thank you. It's been a great conversation. It's really gratifying for someone like me, who is not a music therapist, to get to talk to you, a music therapist of great distinction, about this work. Everything that you have said—the questions you asked, the comments you made, the observations you shared—suggest to me that you absolutely get it. As for what can come out of this book and how it can be applied by other people doing other kinds of work, I would like to conclude by saying that if the music therapy profession as a whole ends up engaging with this work with the kind of insight and depth you have, I predict some wonderful developments and innovations moving forward. I hope to be an integral part of that bright, interdisciplinary, and neurodiverse future, so be sure to keep me in the loop!

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Correction notes: The last sentence in Kenneth Aigen's biography was corrected after the initial publication of the paper. The corrected version was published on 23rd September 2020.

REFERENCES

Aigen, K. (2005). *Music-centered music therapy*. Barcelona Publishers.

Bakan, M.B. (1999). *Music of death and new creation: Experiences in the world of Balinese gamelan beleganjur*. University of Chicago Press.

Bakan, M.B. (2009). Measuring happiness in the 21st century: Ethnomusicology, evidence-based research, and the new science of autism. *Ethnomusicology, 53*(3), 510-518.

Bakan, M.B. (2012). *Making change: Music, meaning, and autism*. TEDxFSU, 24 September 2012, Turnbull Conference Center, Florida State University.

Bakan, M.B. (2020). *Music and autism: Speaking for ourselves*. Oxford University Press.

Bakan, M.B., Koen, B., Kobylarz, F., Morgan, L., Goff, R., Kahn, S., & Bakan, M. (2008). Following Frank: Response-ability and the co-creation of culture in a medical ethnomusicology program for children on the autism spectrum. *Ethnomusicology, 52*(2), 163–202.

Grandin, T. (2006). *Thinking in pictures: My life with autism (*2nd ed). Vintage Books.

Prizant, B.M., Wetherby, A.M., Rubin, E., Laurent, A.C., & Rydell P. (2006). *The SCERTS model: A comprehensive educational approach for children with autism spectrum disorders*. Paul H. Brookes.

Ελληνική περίληψη | Greek abstract

Μια συζήτηση για το *Music and Autism: Speaking for Ourselves*

Michael B. Bakan | Kenneth Aigen

ΠΕΡΙΛΗΨΗ

Σε αυτή τη συζήτηση, ο μουσικοθεραπευτής Kenneth Aigen παίρνει συνέντευξη από τον εθνομουσικολόγο Michael Bakan πάνω στο θέμα του πρόσφατου βιβλίου του Bakan, *Music and Autism: Speaking for Ourselves*

(Μουσική και Αυτισμός: Μιλώντας για τον Εαυτό μας). Πολλά θέματα και ζητήματα εξετάζονται, από την προάσπιση του αυτισμού και την νευροποικιλομορφία έως τις συγκριτικές συνεκτιμήσεις και αντιπαραθέσεις μουσικοθεραπευτικά βασισμένων και εθνομουσικολογικών προσεγγίσεων για την εμπλοκή των αυτιστικών ατόμων μέσω της μουσικής. Κατά τη διάρκεια της συζήτησης, ο Bakan εξιστορεί τα διάφορα στάδια της δουλειάς του πάνω στο θέμα, από το Music-Play Project (το πρότζεκτ Μουσική-Παιχνίδι), στο Σύνολο Artism, μέχρι το πρότζεκτ για το βιβλίο *Music and Autism: Speaking for Ourselves*. Όλο αυτό το έργο του το διατρέχει η συνεχής επισήμανση για την προσπάθεια κατανόησης των ατόμων σύμφωνα με τους δικούς τους όρους –ως ειδικοί στο να είναι αυτό που είναι– σε αντίθεση με την απόπειρα της αλλαγής των ανθρώπων μέσω θεραπευτικών παρεμβάσεων. Αυτή η αντίληψη ουσιαστικά προσδιορίζεται διττά, τόσο ως θεμελιώδης διάκριση όσο και ως ένα ισχυρό σημείο στο οποίο συγκλίνουν εθνομουσικολογικές και μουσικοκεντρικές μουσικοθεραπευτικές προσεγγίσεις.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

εθνομουσικολογία, νευροποικιλομορφία, Σύνολο Artism, E-WoMP (Exploratory World Music Playground), μελέτες για την αναπηρία, αποδοχή του αυτισμού, εκ νέου παρουσίαση (re-presentation), διαταραχή αυτιστικού φάσματος, ενσυναίσθηση (στον αυτισμό), αυτο-προάσπιση του αυτισμού (autism self-advocacy)

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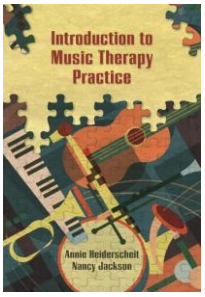
BOOK REVIEW

Introduction to music therapy practice (Heiderscheit & Jackson)



Reviewed by Caroline Anderson

Bluebell Hospice, UK

Title: Introduction to music therapy practice **Authors:** Annie Heiderscheit & Nancy Jackson **Publication year:** 2018 **Publisher:** Barcelona Publishers **Pages:** 305 **ISBN:** 978-1-945411-30-4

REVIEWER BIOGRAPHY

Caroline Anderson works as a music therapist in a children's hospice in the UK. Her clinical experience includes adults and children with learning disabilites and autism spectrum disorders, and also in young oncology. She has a particular interest in skill-sharing with carers and parents and has undertaken a number of skill-sharing projects in Rwanda and the UK. Caroline will shortly be completing her doctoral studies examining cultural difference in music therapy practice. [c.m.anderson@hotmail.co.uk]

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Introduction to Music Therapy Practice sets out a wide range of music therapy practices and approaches through descriptive case studies and accompanying narratives drawing on current research. Heiderscheidt and Jackson, both music therapy educators, have compiled a textbook to accompany introductory courses in music therapy for non-music therapists. They use case studies as the most engaging route into understanding the breadth of music therapy practice. Each subsection of the book begins with a case study that provides a springboard to considering aspects of music therapy techniques as well as the wider context in which they take place, for example, information on physical and mental illness, and the kinds of services that provide music therapy within these fields. The textbook is primarily intended for non-music therapists and their educators, and as such serves to open up the world of music therapy to non-specialists. The 48 case studies are contributed by 29 clinicians from five countries, demonstrating huge variance in practices and approaches; the book is therefore an overview of many different approaches, with the case studies bringing the focus back to the individuals at the heart of the work.

Annie Heiderscheidt and Nancy Jackson work as music therapy researchers, clinicians and directors of music therapy training courses in the United States, in common with most of the contributors to this book; this context influences its overall tone. Although the examples of music therapy practice are provided from music therapists of several nationalities, and the research evidence provided is from a range of international sources, other supporting information such as disease epidemiology, the health insurance system, and history of the profession uses a United States perspective.

The 15 chapters of *Introduction to Music Therapy Practice* are intended to align with a typical 15-week college semester. The book is divided into four main sections with 12 case studies in each, covering the identified four music therapy techniques: re-creative, receptive, compositional and

improvisational music therapy. These are preceded by an introductory section that provides accessible, research-based answers to questions such as 'what is music?', 'what are health and wellbeing?' and 'why use music as therapy?' Each chapter concludes with a glossary of terms (highlighted in bold in the main text), and the references from that chapter, rather than a list of all references at the end of the book. This approach serves the book's potential use as a textbook where individual chapters may be considered in isolation, but also makes it easier for the reader to explore the many references as they go along.

Section A, 'Re-creative Music Therapy', describes music therapy sessions with pre-composed music actively used by music therapy clients, as opposed to receptive methods. The examples given include singing familiar songs with people with Parkinson's disease and singing lullabies in a neonatal intensive care unit. Most case studies introduce wider information about that particular area of clinical practice. For example, a case study involving therapeutic piano lessons with a girl with Down's syndrome then includes additional information on Down's syndrome and other intellectual disorders, and the rationale and benefits of therapeutic music lessons. The section ends with eight supplementary case studies employing re-creative methods and some additional examples of research in this area.

The variations of 'Receptive Music Therapy' are explored in Section B. The first example, that of active music listening with a mechanically ventilated patient in an intensive care unit is followed by contextual information on mechanical ventilation, intensive care, use of active music listening with such patients and a rationale for when such an approach may be employed, including for relaxation. The Bonny method of Guided Imagery and Music (GIM) and other specialised receptive methods are described, similarly illustrated with case studies.

Section C, 'Compositional Music Therapy', presents therapeutic applications of song, instrumental and multimedia composition across the contexts of bipolar disorder, developmental disability, and through case studies referring to a wide range of physical, psychological and social disorders. Several of the case studies provide song lyrics written by service users, again bringing focus back to the struggles of real individuals, and the intimacy of music therapy relationships. As with other chapters, a review of the research and evidence base follows.

The fourth section, 'Improvisational Music Therapy', initially presents the Nordoff-Robbins music therapy approach with two case examples, then broadens into other improvisation based approaches exemplified in case studies situated in a forensic mental health setting, a care setting for people with dementia and a residential eating disorder unit.

Following the four main sections on music therapy techniques comes a chapter describing various clinical contexts; hospitals, days services, special education, and community based care. An overview of each setting with a diagram of referral, treatment and evaluation pathways is given to demonstrate the differences in music therapy delivery. This is followed by a chapter describing the development of music therapy in the United States. An appendix listing websites and journals representing a more international perspective than the preceding chapter is included.

As a UK trained and practising music therapist, my own background is in improvisational music therapy informed by psychoanalytic theory. Perhaps this is inevitable in a book that seeks to cover so much ground, but I felt that my particular music therapy approach was somewhat under-represented, with only a nod to this model and its pioneers in the form of a short paragraph. I was

also interested to reflect that while I consider myself an improvising music therapist, as I read through the sections I realised that I use techniques from all four sections – re-creative, receptive, compositional, improvisational – in my clinical work. The book indeed includes reminders of how in real music therapy sessions methods are often combined or flow from one to another.

Introduction to Music Therapy Practice is concise, far-ranging and scholarly, designed to open up the breadth of music therapy practice to non-specialists. The case studies provide colourful snapshots that both bring the techniques to life in the mind of the reader and energize the theory. They have been carefully curated to fit with the rest of the text, which has clarity and conciseness; this is necessary in a book that contains such a wealth of information. There is a marked United States perspective at times that makes some sections less relevant to readers outside this context although this text does cover a broad range of music therapy techniques. As a practicing music therapist I would be more likely drawn to books that focus in more detail on my own areas of interest, although I greatly enjoyed the tour through the different types of practice exemplified, and learned from the many experienced contributors.

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ΒΙΒΛΙΟΚΡΙΤΙΚΗ

Θεραπευτικές προσεγγίσεις μέσω της τέχνης (Τσέγρας)

Κριτική από τον Μίλτο Χαραλαμπίδη

Ανεξάρτητος επιστήμονας, Ελλάδα

Τίτλος: Θεραπευτικές προσεγγίσεις μέσω της τέχνης **Συγγραφέας:** Νικόλαος Τσέγρας **Έτος δημοσίευσης:** 2014 **Εκδότης:** Τόπος **Σελίδες:** 256 **ISBN:** 978-960-499-079-5

ΒΙΟΓΡΑΦΙΑ ΚΡΙΤΗ

Ο **Μίλτος Χαραλαμπίδης** σπούδασε ανώτερα θεωρητικά στην Μουσική Σχολή Αγίας Παρασκευής, ενοργάνωση πνευστών οργάνων στο Πειραματικό Ωδείο Ψυχικού και σαξόφωνο στο Δημοτικό Ωδείο Αγίας Παρασκευής. Το 2014 ολοκλήρωσε το μεταπτυχιακό πρόγραμμα σπουδών στη Μουσική Ψυχολογία-Μουσικοθεραπεία στο πανεπιστήμιο της Jyväskylä στην Φινλανδία (MA Music Psychology, Major Music Therapy). Παράλληλα με τις μουσικές του σπουδές σπούδασε Θεολογία και Ελληνική Νοηματική Γλώσσα. [miltos87@gmail.com]

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Το βιβλίο του Νικόλαου Τσέργα, *Θεραπευτικές Προσεγγίσεις Μέσω της Τέχνης*, που δημοσιεύτηκε από τις εκδόσεις ΤΟΠΟΣ το 2014, αποτελεί ένα εισαγωγικό κείμενο για τον Έλληνα αναγνώστη που ενδιαφέρεται για μια πρώτη επαφή με την εφαρμογή των τεχνών στη θεραπευτική διαδικασία. Δεν αποτελεί μια εξαντλητική λίστα των θεραπευτικών τεχνών, αλλά αναφέρεται στις τρείς περισσότερο γνωστές θεραπείες μέσω τεχνών: την εικαστική θεραπεία, τη μουσικοθεραπεία και το ψυχόδραμα.

Όντας ο ίδιος ο συγγραφέας διδάκτωρ ψυχολογίας/ψυχοθεραπείας με μεταπτυχιακές σπουδές στην ψυχαναλυτική ψυχοθεραπεία και την κοινωνική ψυχιατρική, η προσέγγιση του στις θεραπευτικές τέχνες είναι κυρίως ψυχοδυναμική/ψυχαναλυτική. Επιπλέον, παρουσιάζει και αναλύει τις θεραπευτικές τέχνες στο πλαίσιο των ομαδικών θεραπευτικών παρεμβάσεων, θεωρώντας πως έτσι γίνεται ευκολότερα κατανοητή η έννοια της θεραπευτικής παρέμβασης μέσω της τέχνης. Για τον λόγο αυτό το πρώτο κεφάλαιο του βιβλίου είναι αφιερωμένο αποκλειστικά στην ομαδική θεραπεία.

Το βιβλίο χωρίζεται σε πέντε κεφάλαια τα οποία με τη σειρά τους χωρίζονται σε υποενότητες στις οποίες παρουσιάζονται και αναλύονται τα επιμέρους θέματα και ζητήματα. Συγκεκριμένα αναπτύσσονται η *Εικαστική Θεραπεία*, η *Μουσικοθεραπεία* και το *Ψυχόδραμα*. Ακόμα, γίνεται αναφορά και στις *Εκφραστικές και Δημιουργικές Θεραπείες*, στο συνδυασμό δηλαδή διαφόρων τεχνών στη θεραπευτική διαδικασία όπως είναι η ζωγραφική, η μουσική, η αφήγηση και η φωτογραφία.

Προσωπικά, διαβάζοντας το βιβλίο αυτό από τη σκοπιά του μουσικοθεραπευτή (ψυχοδυναμική μουσικοθεραπεία), και χωρίς υπόβαθρο στις άλλες θεραπευτικές τέχνες, αποκόμισα πολλές πληροφορίες για το ρόλο και την αξία της εικαστικής και της υποκριτικής τέχνης στη θεραπευτική

διαδικασία. Όσον αφορά τη μουσικοθεραπεία, οι πληροφορίες είναι πολλές και συμπυκνωμένες. Ο Τσέργας προσφέρει πολλά βασικά στοιχεία σχετικά με τη μουσικοθεραπεία, όπως τον ορισμό, την ιστορία και τις θεωρητικές προσεγγίσεις της, καθώς και τα εν δυνάμει οφέλη που μπορούν να αποκομίσουν οι θεραπευόμενοι.

Το δυνατότερο σημείο του βιβλίου ίσως είναι η πλούσια βιβλιογραφία του. Είναι χωρισμένη ανά κεφάλαιο με πάνω από 150 αναφορές σε κάθε τέχνη, έτσι ο αναγνώστης μπορεί εύκολα να ανατρέξει σε πηγές για περαιτέρω μελέτη και έρευνα. Μόνο στο κεφάλαιο της μουσικοθεραπείας υπάρχουν πάνω από 200 βιβλιογραφικές πηγές, αρκετές από τις οποίες είναι από σημαντικούς συγγραφείς του χώρου όπως οι David Aldridge, Juliette Alvin, Kenneth Bruscia, Paul Nordoff και Clive Robbins, Amelia Oldfield, Mercedes Pavlicevic, Mary Priestley, Chava Sekeles, Tony Wigram, αλλά και από σχετικά επιστημονικά περιοδικά όπως *Journal of Music Therapy*, *Music and Medicine*, και *Nordic Journal of Music Therapy*. Δυστυχώς όμως απουσιάζουν ελληνικές αναφορές σε επιστημονικά συγγράμματα, περιοδικά και οργανισμούς μουσικοθεραπείας. Η μόνη ελληνική αναφορά που έχουμε στο κεφάλαιο της μουσικοθεραπείας είναι στον Δημήτρη Αθανασιάδη (1984) η οποία σχετίζεται με την ιστορία της μουσικής. Παρομοίως, και στα άλλα κεφάλαια του βιβλίου παρατίθενται αναφορές μόνο σε ξενόγλωσσες πηγές, επιστημονικές εταιρίες και περιοδικά.

Αδύνατα σημεία του βιβλίου αποτελούν οι ελάχιστες πληροφορίες για την εκπαίδευση στη μουσικοθεραπεία – όπως και στις άλλες θεραπευτικές τέχνες – πράγμα σημαντικό δεδομένης της επικρατούσας κατάστασης στην Ελλάδα, αλλά και σε πολλές άλλες ευρωπαϊκές χώρες, σχετικά με την κατάρτιση και εκπαίδευση των μουσικοθεραπευτών και των λοιπών θεραπευτών μέσω τέχνης (βλ. Κάρκου, Τσίρης & Καγιάφα, 2019). Άλλα θέματα που δεν αναφέρονται στο βιβλίο αφορούν την επαγγελματική αναγνώριση και τη θέση του θεραπευτή μέσω τέχνης στην Ελληνική και ευρωπαϊκή αγορά εργασίας, τη στάση της Ελληνικής κοινωνίας και πολιτείας απέναντι στις τέχνες, την ψυχοθεραπεία και στο συνδυασμό των δύο. Αναγνωρίζω βέβαια τον περιορισμένο χώρο και το συγκεκριμένο στόχο του βιβλίου ο οποίος είναι να παρουσιάσει τις θεραπευτικές μεθόδους μέσω της τέχνης, την εφαρμογή τους και τα οφέλη τους, πράγμα που επιτυγχάνει με ένα ξεκάθαρο και επαγγελματικό τρόπο.

ΒΙΒΛΙΟΓΡΑΦΙΑ

Αθανασιάδης, Δ. (1984). *Ιστορία της μουσικής*. Θεσσαλονίκη: Έκδοση Μακεδονικού Ωδείου.

Κάρκου, Β., Τσίρης, Γ., & Καγιάφα, Ν. (2019). Εκπαίδευση και επαγγελματική αναγνώριση για τους θεραπευτές μέσω τέχνης: Ευρωπαϊκές προοπτικές. Στο Λ. Γιώτης, Δ. Μαραβέλης, Α. Πανταγούστου & Ε. Γιαννούλη (Επιμ.), *Η συμβολή των ψυχοθεραπειών μέσω τέχνης στην ψυχιατρική θεραπευτική* (σσ. 332-340). Αθήνα: Εκδόσεις Βήτα.

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FILM REVIEW

Operation syncopation: Music therapy and autism (Thompson, Ed.)

Reviewed by Efrat Roginsky

University of Haifa, Israel

Title: Operation syncopation: Music therapy and autism **Film director and editor:** Maxim Thompson **Publication year:** 2017

REVIEWER BIOGRAPHY
Efrat Roginsky is a classical guitarist and music therapist, specialising in working with non-speaking persons with neurodevelopmental disabilities and their families. Along with her music therapy practice Roginsky supervises a regional arts therapies group for the Israeli Board of Education, and teaches at the University of Haifa MA Music Therapy programme. Her PhD research explores the personhood of children with profound cerebral palsy through their musicality and appropriation of music. Roginsky is also part of an international group aiming to study the possible contributions of the Neurodiversity movement to the music therapy profession. [roginskyefrat@gmail.com]

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This review attempts to share some impressions and thoughts regarding Amelia Oldfield's documentary film *Operation Syncopation*. The film, which was directed and edited by Maxim Thompson, won the audience award for best documentary at the 37th Cambridge Film Festival. Its full English version is available on YouTube. Before beginning the review, I should make it clear that I myself, a music therapist, do not own lived autistic experience, nor am I a parent to autistic individuals. This review is therefore written from my own perspective. Also, informed by the Neurodiversity discourse, the term 'autistic' is used here rather than person-first language, to recognise autism spectrum individuals as whole beings, and not owning separate, disabling characteristics.

THE FILM

Sixteen years ago, as part of her doctoral research, Amelia Oldfield documented her music therapy sessions with ten autistic children, in the presence of their parents. This research generated additional exploration, writing, and teaching (for example: Oldfield, 2003, 2006; Oldfield, Bell & Pool, 2012); the documented footage holds special value in the music therapy literature. Presently, Oldfield, assisted by two music therapist colleagues, Emma Davies and Dawn Loombe, invited the research participants to revisit their videos, share their past experiences, and reflect on the outcomes of the music therapy.

The film begins with some background: the earlier research and the present follow-up are described in running headlines, music therapy videos, and through the music therapists' discussions.

Then, each parent is interviewed as they watch their video segments. Some of the child clients, young adults now, join their parents. Talking, singing, playing, and many visual elements – several layers of audio and video are played together, in an intense, kaleidoscopic dance.

Memories, thoughts and emotions emerge during the interviews. The music in therapy is discussed, and the means whereby it meets the needs of every parent and child.

Parental knowledge arises regarding their children's diagnosis, communication and the influences of music therapy. The young adults participate as well. Some of them, uneasy with direct or verbal communication, offer their nonverbal input. Then, parents share their advice with families newer to autism, and the music therapists consider the efficacy of the treatment, and potential improvements. Towards the end, the filmmakers are introduced: a father, and his son, formerly a child client of Oldfield's. It is more apparent now how this film has not only a historical value; it echoes the intricate dialogue of parents with their children, and child clients with their therapist.

Overall, it is a complex film, loaded with documentary material, reflection, visual ideas, professional and academic effort; it integrates past and present approaches to music therapy, autism and therapy clients.

THE SENSORY ENCOUNTER

The viewer of this film encounters an array of music, words, continuously shifting perspectives, and ideas. The several layers of information presented all at once require one to stop, watch once more, and process. It felt at times as I was the autistic child, unable to comprehend the gushing stream of information. I needed to find the way through viewing and halting, listening to some parts audio-only, seeing time and time again bits and pieces of the film, to capture the big picture. It has been a unique sensory and intellectual journey.

ACADEMIC, OR ARTISTIC?

The film starts in the general form of an academic document: Oldfield's follow-up study presented through video. The idea to present music therapy research in such a vivid manner was exciting; it reminded me of arts-based research ideas and their scarcity in our profession (Ledger & McCaffrey, 2015). As the film progresses, it seems as though the editor's artistic intentions intervene with Oldfield's academic ones: two aesthetic languages collate, combine, and towards the end of the film, a more free and emotional spirit takes over.

THE PARTICIPANTS

Each parent had a unique contribution; some shared their memories and thoughts fluently, and others were more reserved. A few parents moderated their young adult's communication, while others were too immersed in their private emotional journeys. Some young adults seemed uneasy or remote, supplying short replies, and with some behaviours that may have suggested irritation.

For me, it has been a sensitive experience watching a parent talk *about* their young adult, not *with* them, especially when difficult issues were encountered. A few parents enabled their vulnerable children to take part through various expressive modalities rather than direct verbal interview.

NONVERBAL COMMUNICATION

The parents remembered the pride they felt as their non-speaking children showed attention, playfulness, creativity, and coherency in the music therapy; these children's personhoods were unveiled through the musicking. Furthermore, some young adults who found it hard to talk contributed to the film by sending their music, visual arts, and creative writing. This was both touching and animating. It is indeed worth recognising that, along with music therapy, a broad communicative world exists beyond the borders of our typical, verbal conversation.

PLAYFULNESS

Besides the music, Oldfield demonstrates a high level of playfulness; using her body, the space and the musical instruments to engage with the children and their parents synchronously, communicatively, and energetically. This kind of engagement, highly appreciated by the interviewed parents, is typical of Oldfield's works, and is also evident in her other films and publications, especially her book on interactive music therapy (Oldfield, 2006).

AN ECOLOGICAL PERSPECTIVE

Mainly parent-child dyads were shown in the past and present; spouses and siblings were not included. The only triad – father, mother and child – revealed that one parent has been less affectionate or engaged. This scene was never reflected upon in the film. Contemporary approaches involve whole families in the music therapy of their children with developmental challenges, meaning to establish firm communicative and psychological foundations through the musicking (Jacobsen & Thompson, 2017).

NOTHING ABOUT US WITHOUT US

Different autism-rights movements advocate involving autism spectrum individuals in any professional work or decision-taking concerning their condition (see Bolton, 2018). The present film begins with the academic background, the therapists and the parents' experiences; only then, bit by bit, do autistic voices emerge. As this occurs, the film becomes a little less orderly and coherent; its flow and rhythm change, and a powerful experience takes over. Unique voices are heard now: a girl tells her story through music and dancing. A piano is playing, and poetry is read. Then, a young participant, true to himself, insists on not speaking despite the interviewer's attempts. The dialogue

between theory and art, academic research versus advocacy, typical and autistic, is indirect, and yet, it is present and powerful. But the grand finale is reached only as the film comes to end, and the director, a former child client in his twenties, speaks. No, he does not remember music therapy as anything special as a child: “You are just doing your job," he shares, smiling. "You just get taken into rooms, you do things, and you get taken out of those rooms...it was never really for me anyway, I just existed… It was for you… Music therapy wasn't really for the children so much as it was for the parents," says the young film editor, looking at his father. "I think you're right," the father replies.

As music therapy practitioners, lecturers and researchers, we tend to focus on the power of music, the benefit of our methods, or the future of the profession. Are we aware, though, that even the most effective therapy is but a ripple in the fuller lives of our service-users and their families? Beyond the historical and academic significance of this film, Oldfield's brave and humble attitude stands out, as she allows the children's unexpected message to come through: therapists do not understand a lot; in fact, our value in our service-users' experiences may be marginal regarding their ongoing efforts to fit in with the expectations of their everyday, their family, and the ‘typical’ society. In this film, Oldfield seems prepared to learn, and have the viewers listen and learn as well. Watching the film again and again, I considered it as highly useful food-for-thought for anyone in our profession.

REFERENCES

Bolton, M. J. (2018). With the silence of a thousand cries: extremes of autistic advocacy. *Disability & Society*, *33*(6), 980-984.

Jacobsen, S. L., & Thompson, G. (Eds.). (2017). *Music therapy with families*: *Therapeutic approaches and theoretical perspectives*. London: Jessica Kingsley Publishers.

Ledger, A., & McCaffrey, T.M. (2015). Performative, arts-based, or arts-informed? Reflections on the development of arts-based research in music therapy. *Journal of Music Therapy, 52*(4), 441–456.

Oldfield, A. (2003). *Music therapy with children on the autistic spectrum: Approaches derived from clinical practice and research.* Doctoral thesis, Anglia Ruskin University, Cambridge, UK.

Oldfield, A. (2006). *Interactive music therapy in child and family psychiatry: Clinical practice, research and teaching*. London: Jessica Kingsley Publishers.

Oldfield, A. Bell, K., & Pool, J. (2012). Three families and three music therapists: Reflections on short term music therapy in child and family psychiatry. *Nordic Journal of Music Therapy, 21*(3), 250-267.

Oldfield, A. (2017). The first ‘themed’ British Journal of Music Therapy: An introduction to music therapy with families. *British Journal of Music Therapy, 31*(1), 5-11.

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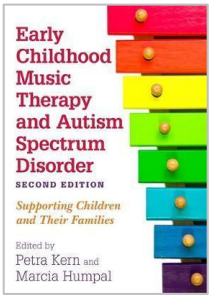
BOOK REVIEW

Early childhood music therapy and autism spectrum disorder: Supporting children and their families (2nd ed., Kern & Humpal, Eds.)



Reviewed by Emma Donnelly
Music Therapy Connections NI, UK

Title: Early childhood music therapy and autism spectrum disorder: Supporting children and their families **Editors:** Petra Kern and Marcia Humpal **Publication year:** 2019 **Publisher:** Jessica Kingsley Publishers **Pages:** 320 **ISBN:** 9781849056304

REVIEWER BIOGRAPHY
Emma Donnelly is the founder and director of Music Therapy Connections NI. She obtained a Masters in Music Therapy from the University of Limerick, Ireland. She has since worked as a music therapist with children and young adults with learning disabilities within both school and hospital settings. She specialises in working with children and young adults with autism and challenging behaviour. Most recently she has completed the NICU music therapy training and is in the process of setting up the first NICU music therapy programme of its kind in Northern Ireland. [emma@mtcni.co.uk]

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Editors Kern and Humpal introduce the book by stating “ASD is currently the most served population in music therapy practice worldwide” (p. 11). If we examine published material such as books and research in the area of music therapy with this client group, this would certainly seem the case. In addition, the theory and research surrounding Autism Spectrum Disorder (ASD) is constantly advancing, and therefore it is important that music therapists who are working within this field receive the latest evidence-based research to inform their practice.

The book opens by giving a detailed summary of the latest diagnostic criteria of ASD according to the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM V). This chapter is essential for informing any therapist working in the field of autism. It outlines the core features of ASD and clearly describes the new ‘Severity Levels’ one to three, which are now given at point of diagnosis (p. 15). These levels will inform music therapists about the degree of ASD the child is living with and determine the support needed. The dyad of impairment or diagnostic features are described in great detail and are also paired with an accompanying link to a bank of online video clips and professional trainings.

The authors promote the idea that evidence-based practice (EBP) in music therapy provides the practitioner with recent evidence-based practices which as stated are “the foundation for providing effective interventions to young children with ASD and their families” (p. 34). This chapter, together with the following two chapters, focus on this aspect of the work. They will especially appeal to the newly qualified music therapist as they clearly outline the importance of developing and implementing evidence-based practices in order to achieve the best clinical outcome for the client and their family.

Chapter 3 focuses on effective music therapy interventions that are heavily supported with scientific evidence. This chapter outlines and describes systematic reviews; independent studies and two meta-analyses prominent in the ASD related music therapy literature. The chapter concludes by urging the music therapy community to apply scientific rigour when conducting research in order to provide the best evidence-based service to their clients.

Chapter 4 moves onto assessment in music therapy. I had a particular personal interest in this chapter as it can be difficult to find one assessment tool which meets the multiple needs associated with ASD. Due to the diverse spectrum of autism, assessment tools often need to be adapted and individualised to meet the specific needs of each client such as ASD and severe learning difficulty, ASD and sensory processing disorder, and ASD and ADHD. As clinicians, we know that assessment is crucial if we are to determine eligibility for music therapy or to develop and identify SMART clinical goals. This chapter focuses on the importance of assessment. It lists clinical assessment tools in a clearly laid out table identifying the age group, population and purpose of each assessment. I found this table particularly useful and very user friendly. The chapter concludes with examples of how the Four-Step Assessment Model, the MT-MRB assessment and the SCERTS model can be used to determine eligibility, gather information and inform clinical goals.

Chapters 5 to 9 offer the reader a comprehensive insight into a variety of music therapy approaches, which may be applied within the music therapy intervention. These approaches range from a behavioural approach, instructional practices, Social Stories, Nordoff-Robbins approach and a Neurodevelopmental approach. Each approach is described in a detailed manner offering the reader very different evidence-based approaches which can be embedded into a therapists' clinical practice.

Chapter 10 is an excellent chapter and a much advised read. It addresses sensory processing in children with ASD, which is a core feature of autism. It is therefore important for a therapist to have a detailed understanding of sensory processing and how sensory issues may have an impact on the music therapy intervention. This section introduces the reader to the complexity of the sensory system. It outlines the seven senses and highlights the importance of having understanding around these systems in order to fully understand sensory features and their functions. Recent research talks of an eighth sense 'Interoception' (Hinton, 2019). Although this has not been discussed in this chapter it is important for therapists to consider. Interoception is a lesser-known sense, which refers to sensations within the body that help one understand and such sensations, e.g., hunger, pain, thirst. This may lead to difficulties in self-regulation therefore having a negative impact on the music therapy intervention. The chapter ends with suggestions for music therapy practice. It advocates working as part of a multi-disciplinary team with occupational therapists to use a variety of evidence-based interventions, which will be the most beneficial to children with ASD and complex sensory responses.

Chapter 11 is an informative chapter with a focus on communication development. It provides an overview on communication features in children with ASD. Like its previous chapter, it too has a focus on collaborative practices. It describes the intentional use of augmentative and alternative communication in clinical practice. This chapter also provides recent research snapshots related to music and communication development (pp. 217-218).

Inclusive practice and building capacity among families by empowering them to embed music therapy strategies into daily family routines and activities form the focus of chapters 12 and 13.

I found Chapter 13 particularly interesting and a worthwhile read. It highlights the importance of working together with parents as part of a team to empower them to include music in the home environment to support the core areas of development. Children with ASD often find transferring skills difficult as DeLoach (p. 247) explores in this chapter, emphasising the importance of practicing skills across multiple environments (e.g., home, school) in order for learning to occur. The chapter concludes by giving intervention ideas for parents around social communication, emotional regulation and transactional support.

Chapter 14 offers practical guidelines for advocacy for children with ASD and their families. It discusses challenges of advocacy and concludes with steps to effective advocacy. A reflective chapter to conclude the book follows this nicely. The journeys of four music therapists who have both a professional and personal perspective on working with and raising young children with ASD are described and captured in informal interviews. This chapter offers an insight into the unique challenges that face professionals who are also parents of children with ASD. It also gives an insight into the impact on family life for siblings and extended family members. There is a reoccurring message from each parent; “Use a strengths-based approach” and be a “tireless advocate” (p.288). This chapter offers many suggestions for the music therapist to inform their future practice.

This book will appeal to a broad spectrum of readers with an interest in ASD. I would especially recommend this book to newly qualified therapists or those beginning work within the field of autism.

REFERENCES

Hinton, C. N. (2019). *Improving attention regulation in children: An interoceptive awareness approach. An evidence-based capstone project in occupational therapy.* Doctoral thesis, Chatham University, Pittsburgh, PA, USA. Retrieved from https://s3.us-east-2.amazonaws.com/chathamlibsp/gradcapstones/2019/HintonC.pdf

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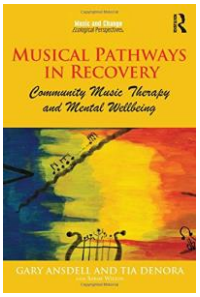
BOOK REVIEW

Musical pathways in recovery: Community music therapy and mental wellbeing (Ansdell & DeNora, with Wilson)



Reviewed by Penny Warren

Victoria University of Wellington, New Zealand

Title: Musical pathways in recovery: Community music therapy and mental wellbeing **Authors:** Gary Ansdell & Tia DeNora, with Sarah Wilson **Publication year:** 2016 **Publisher:** Routledge **Pages:** 263 **ISBN:** 9781409434160

REVIEWER BIOGRAPHY

Penny Warren trained as a music therapist at Guildhall School of Music and Drama and worked in the NHS and MusicSpace, Bristol, before emigrating to Aotearoa, New Zealand, in 1995. She works as a music therapist in the areas of adult mental health, children and families, and as a co-facilitator of a neurological choir, SoundsWell Singers. She is also beginning a PhD at Victoria University of Wellington. [pennywarrenmt@gmail.com]

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> […] recovery is a process in time, something that comes about, something that is brought along with the person's engagement with life, something that is necessarily about the whole person and their lives, loves and aspirations. (p.215)

This is a fascinating, complex and stimulating book, with clear relevance in the current climate of the recovery model within mental health care and the congruence of community music therapy in supporting the ethos of this model. Gary Ansdell and Tia DeNora's collaboration in writing *Musical Pathways in Recovery: Community Music Therapy and Mental Wellbeing* (2016), is the final book in a trio from the *Music and Change: Ecological Perspectives* series. The trio began with Tia DeNora's *Music Asylums: Wellbeing Through Music in Everyday Life* (2013), followed by Gary Ansdell's *How Music Helps in Music Therapy and Everyday Life* (2014). The authors describe the series of books as a triptych, with *Musical Pathways in Recovery* (2016) placed as the centrepiece, bringing together the music therapy, ecological and music sociological perspectives of the authors. From the outset, an ecological perspective for music is at the centre of the text exploring how music therapy can uniquely or specifically help people in a particular situation, rather than fitting the evidence into a standard medical treatment model. The experience and expertise of Ansdell and DeNora shine through in this skilfully crafted work.

The book centres around the SMART Music project, which began in 2005 under the name Chelsea Community Music Therapy Project. It then became part of the charity SMART (St Mary Abbots Rehabilitation and Training). This work covers the first ten years of the music therapy project, with the ethnographic research branch encompassing a six-year timeframe. The SMART members live with severe mental illness (SMI) and attend the music therapy session in a café that is situated

within the SMART building in the grounds of a hospital in London, UK. The pathways that members take to come to the sessions may be from the mental health unit in the hospital and/or the community, and can vary for each person at different times. The lengthy timeframe of the research has enabled descriptions of "how music featured in the respondent's daily experience longitudinally across, and how they used and related to music on their own, and on music's, terms" (p.7). These are shared through vivid descriptions and stories that map the unique recovery journeys that SMART members are taking.

The overriding message for the project is that it is focused on working 'with' people. As a music therapist now living in Aotearoa, New Zealand, the following Whakataukī (Māori proverb) seems to capture the essence of SMART Music:

> He aha te mea nui o te ao?
> He tāngata, he tāngata, he tāngata
>
> [What is the most important thing in the world?
> It is people, it is people, it is people]

WHAT YOU WILL DISCOVER

With a project of this length, consideration about how to present the complexity and richness of the vast amount of data in a form that offers detail along with the landscape of the work has been carefully considered. The work is multi-layered, and this has influenced the way the work is presented. Each section has aspects that are interwoven and do not exist on their own.

The book is written in three parts, with the first being significantly longer than the second and third. Part One is appropriately substantial as this section is about SMART, its members and their journeys. Part Two and Three offer the opportunity to step back and to consider the processes of the research, the researchers, the findings and the ethical considerations, whilst continuing to maintain the connection with SMART members' stories and experiences. A brief Coda written by music therapist Sarah Wilson ends the book. Sarah began working at the SMART project in 2007 and continues running SMART Music that lives on and grows after the book. Sarah is acknowledged for her support, involvement and contribution to the SMART Music project. Two appendices add a further layer of reflection to the processes that are contained in Parts Two and Three.

Part One: *'Musical Pathways'*, is rich, full and multi-layered, consisting of 45 sections. It is hardly surprising that this section is described as 'bulging', as it documents the complex journey of the SMART project over time through multiple aspects. Musical action is being studied ecologically throughout this project. Sections 1-15 cover the first six months of the project and help ground and situate the project within the mental health service, the physical environment and its establishment as part of the community. SMART members are introduced through following their journeys to the SMART venue, and there is a growing sense of the project's emergence and establishment in these initial months. Emerging outcomes are shared by researchers after the six months.

In the early years of SMART, song was a core part of the music in the sessions. The development and use of song are discussed and explored, in, for example, the life of a song within

sessions, and the connection to SMART members' identity and their journeys to wellbeing. Over time, some members expanded the music at SMART into music performances, and into different music projects and forms. This process mirrors the 'ripple effect' present in Community Music Therapy theory (p.151).

The presentation and writing of Part One reveal an absorbing window into the project. It includes carefully written stories of participants and researchers, excerpts from field-note logs, observations from the music therapy sessions, and the exploration of the role of music in participants' personal recovery journeys. Interspersed throughout the 45 sections are text boxes written in different font, visually highlighting that their content is linked to theory and concepts that relate to the music therapy sessions at SMART.

Part Two, *Continuous Outcomes*, offers the question "what is an outcome?". The authors explore, through refreshing reflection, what an outcome might look like other than in a traditional, quantifiable measure. Whilst the findings of the research are presented as a summary of the project's outcomes, as eight themes, the reflective considerations of the broader question enrich the work. There is no clear answer to the question posed, however, this section offers space to use different lenses to consider the question. The authors have created a schema that represents the continuity of outcomes that are present and which highlights that they are not limited to what happens 'during' the process of music therapy. The examples that are included from the SMART members' experiences enhance this concept effectively. The unique, ongoing and non-linear nature of the recovery pathway for each person is thoughtfully acknowledged.

Part Three, *Musical Recovery*, explores the different unfurling aspects and roles of music within the key findings of the project in relation to current thinking and practice in the field of mental health recovery. The development of the recovery movement has challenged the assumptions and norms of the medical model view of SMI over a period of 20-plus years. An overview of this process and the core factors of the recovery model ground the reader in current healthcare practice before returning to the results of the study and a broader view of 'recovery'. Three participants' stories of recovery in relation to music are also shared. Their journeys offer an individual experience with a common motif of recovering pieces of themselves and moving towards experiencing wellbeing.

SOME RESPONSES

As the story of SMART unfolded in the early sections, I was absorbed by the descriptions, experiences and narratives of SMART members. They are skilfully woven throughout, and I was quickly engaged with the layers of their voices and experiences. I was very taken with the story of Eloise and the cymbal which develops throughout the project. Her identity in the group was woven with the cymbal. It was her instrument to play. Her level of participation and musical expression were observed to be linked to her well-being. The cymbal also acted as a catalyst for Eloise to share stories about different aspects of herself and her life. Touchingly, her absence was also represented and acknowledged by the presence and silence of the cymbal in the group. As I read the musical pathways of specific SMART members, reflections about my own clinical work also emerged at times and prompted some "aha" moments. This was particularly so in the reflection and discussions

around the attachments and relationships that were present with specific songs and instruments for different people. The framework that categorised songs that were included over time in the sessions is one I found useful, and which I will consider in my music therapy practice in mental health. Songs' roles are described as 'ubiquitous', 'tethered', 'migrating' or 'novelty' (pp. 69-70).

The complexity of the multiple layers of information presented in Part One in my first reading made it less easy to read and absorb. I found I became saturated and needed to take frequent breaks to allow me to place everything, and to integrate the theories, concepts and reflections. Ansdell and DeNora have carefully considered how they would present their work in a way that captured the many dimensions of the project and thinking around the research. The reader will find their own way to adapt to this.

Part Three, *Musical Recovery*, may be short in length, however, it opens up the developing area of discussion and debate around the models of music therapy practice that align with perspectives and values of the recovery model. Ansdell's voice and work is synonymous with the growth and development of community music therapy. It is no surprise, then, that the ecological perspective on musicking, creating a "musical ecology" (p. 41) and establishing of a musical community at SMART, underpin the work. However, the content of *Recovering Music Therapy* (pp. 222-224) may challenge those who work from a psychodynamic perspective, as there is limited acknowledgement or space to discuss this in relation to the recovery model. I feel it is important for the reader to contextualise the ecological perspective within the life of the music therapy profession and understand its evolution and development.

This book offers an impressive range of content which will be valuable to music therapy students through to experienced music therapy practitioners. I have enjoyed the opportunity to immerse myself in the ecological perspective and further consider its place in my own music therapy practice. This book sits close by when I supervise music therapists, and it is one I have recommended, and will continue to recommend.

REFERENCES

Ansdell, G. (2014). *How music helps in music therapy and everyday life*. Farnham: Ashgate.
DeNora, T. (2013). *Music asylums: Wellbeing through music in everyday life*. Farhnam: Ashgate.

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