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Special feature

Music therapy: A profession for the future

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

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

Guest editor: Inge Nygaard Pedersen

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

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

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

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

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GUEST EDITORIAL

Inge Nygaard Pedersen

Aalborg University, Denmark

Structure of the symposium

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

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

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

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

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

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

Topic of the symposium

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

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

Structure of the special feature

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

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

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

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Dileo, C. (Ed.). (2016). *Envisioning the future of music therapy*. PA: Temple University. Retrieved from http://www.temple.edu/boyer/academicprograms/music-therapy/documents/ENVISIONING_THE_FUTURE.pdf

PART ONE: MUSIC THERAPY IN MENTAL HEALTH

Roundtable presenters:
Pedersen, Grocke, De Backer

Discussion group members
Odell-Miller, Lindvang, Storm

Moderator: Hannibal

A reflexive introduction

Music therapy in mental health

Helen Odell-Miller

Anglia Ruskin University, United Kingdom

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

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

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

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

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

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

feasibility randomised controlled trial.

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

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

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

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

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

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

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

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

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

Finally, the relationship between music therapy and other experiential arts therapies is worthy of further research. There are many similarities between the different arts therapies, but so far there is not a huge body of research demonstrating which arts therapies might be suitable for which situations and needs, and when and how it should be delivered. In conclusion, music therapy has a specific emotional, intellectual, psychological, physiological and social relevance for adults with

mental health issues, and there is convincing research to substantiate this. In the future, more knowledge is needed about specific beneficial outcomes and new research is continuing to investigate these questions.

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Lecture 1

Music therapy in psychiatry/mental health

Inge Nygaard Pedersen

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Introduction

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

Why music?

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

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

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

I think this is a very important explanation as to why music is applicable in mental health care. The

patient cannot be ‘interpreted’ directly from the musical expression, and the patient is the agent of his/her experiences in musical expressions and during music listening. Still, these musical expressions and experiences can be shared with a music therapist who is carefully listening and interacting without interpretation, unless this is mutually understood as a positive opportunity for the patient to understand specific developmental steps.

Another description from Bonde is:

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

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

Bonde also claims that:

“[...] music can have a meaning, even if this can’t be expressed in words. This ‘tacit knowledge’ or ‘inexpressible meaning’ can be found at different levels” (Bonde 2009: 39).

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

Understanding clinical work in mental health

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

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

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

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

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

anxiety of not being understood.

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

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

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

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

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

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

In the next phase, a *phase to identify possible limitations of being in the world and possible new resources for the future*, phase D, the music can help to establish a new identity with more stable inner resources (e.g. through creations of own songs or through listening to preferred music). Musical form can offer a structure in which the patient can be in flow with an emerging integrated identity. Music can be an important carrier of identity in this phase. In a third clinical music

example with the same patient (see CD track 8 in Wigram, Pedersen & Bonde 2002), he has come to a phase where he no longer needs a stable person outside and related to himself to avoid chaos and anxiety. He can now understand that his former need of controlling others in a relationship due to anxiety and a poor feeling of coherence of identity is no longer prevailing. The patient can act more freely in the musical interplay and can join a common flow in the improvisation, and this can be understood as an analogy of how he now has the capacity to relate to other people in a more flexible way.

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

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

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

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

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

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

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

Music therapy – in spite of low motivation

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

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

Flower figures of ‘Why music?’ and ‘Why and when is a music therapist needed?’

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

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

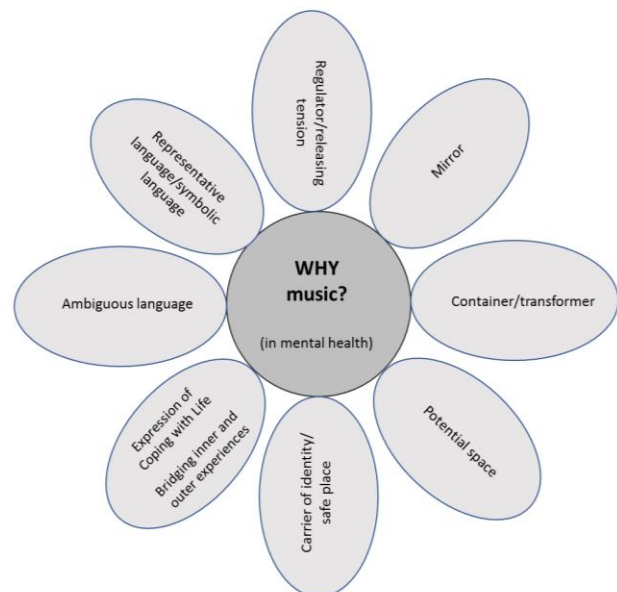


Figure 1: Flower of music

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

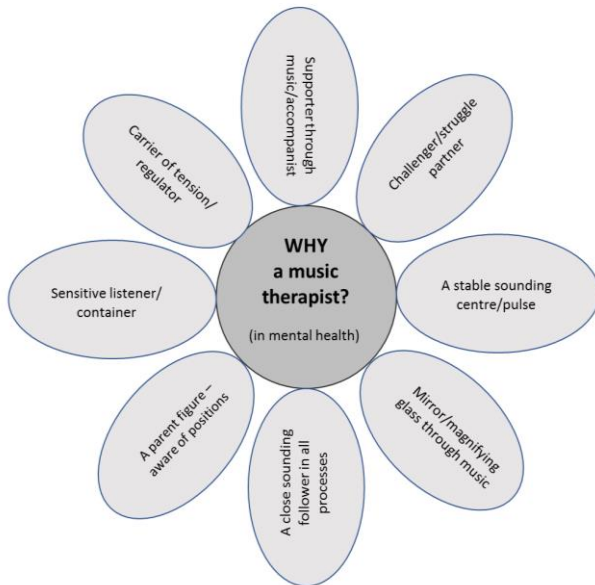


Figure 2: Flower of music therapists

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Lecture 2

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

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

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

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

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

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

therapy comprising ten to 20 sessions has been shown to improve symptoms of depression and anxiety, and to enhance general functioning (Erkkilä et al. 2011).

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

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

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

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

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

B: I enjoyed the collaborative part of it: Working together with other people to create something... the creative part of it was to actually write a song.

H: It was good because we all had an input, so that made it (the song) ours. Our song and a team effort, we all had something in the song. You feel good if you’re in a team and you’ve contributed too. It’s given me more confidence to try new things.

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

'Songs for life' study

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

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

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

Why and when is a music therapist needed?

In order to respond to the question of why and when a music therapist is needed, I will draw on the

comments offered during the focus group interviews, as they illustrate and describe what the participants noticed about the music therapists.

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

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

Theme 1: What was liked: Accomplishment and satisfaction

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

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

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

Theme 2: Reclaiming a love of music

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

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

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

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

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

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

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

Theme 3: Qualities of the music therapists

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

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

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

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

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

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

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

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

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

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

Theme 4: What was not liked

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

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

Reprise: Why and when is a music therapist needed?

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

space that allows time for reflection.

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Reflection paper

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

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Background

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

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

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

The answers

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

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

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

Grocke referred to research findings when talking about group music therapy and songwriting with a group of patients with severe mental health problems. This is a classic way of supporting the idea of music therapy (and indeed any other treatment for that matter). Grocke's presentation, however, does not offer a coherent rationale concerning the two core questions. The argument

is that the research shows improvement and the participants express their appreciation for the treatment, and that in itself is a rationale. There may be obvious reasons for choosing such a strategy for the presentation; there is a time limit, and giving a more in-depth rationale for songwriting as a method in music therapy is a considerable task.

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

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

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

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

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

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

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

way of talking about *why music* must include a purpose. There is a reason for doing it and it is related to the needs and problems of the client in front of us. When that becomes clear, the need for a trained music therapist in contrast to a skilled musician becomes obvious.

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

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

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

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

Roundtable presenters

Ridder, Odell-Miller, Schmid

Discussion group members

Beck, Fachner, Dileo

Moderator: Stige

A reflexive introduction

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

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

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

Three lecture papers and a further reflection paper

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

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

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

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

In her reflection paper, Bolette Daniels Beck (2017) concentrates on music therapy for

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

Comments and reflections

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

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

The many futures of music therapy

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

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

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

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Lecture 1

Music therapy in dementia care and neuro-rehabilitation

Hanne Mette Ridder

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

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

Australia¹, Norway², Sweden³ and the USA^{4,5}.

Why music for persons with dementia?

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

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

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

¹ ABCnet 2016:

<http://www.abc.net.au/catalyst/stories/4421003.htm>

² NRK 2014: <http://www.nrk.no/livsstil/nrk-helene--noe-av-det-sterkeste-jeg-har-opplevd-1.11990203>

³ Wahlgren 2016: <http://singingnurse.se/>

⁴ Trailer, Alive Inside:

<https://www.youtube.com/watch?v=laB5Egej0TQ>

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

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

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

Why and when a music therapist?

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

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

The above clinical approach was applied in two recent randomised controlled trials that showed the positive effect of music therapy on neuropsychiatric symptoms in people with dementia (Hsu et al. 2015; Ridder, Stige, Qvale & Gold 2013). However, the latest updated Cochrane Review on music therapy for people with dementia (Vink, Bruinsma Manon & Scholten Rob 2011) could only include ten studies, all of which did not satisfy the quality to be included in a meta-review. It is therefore not (yet) possible to claim that there is evidence for

music therapy; however, a number of review studies on non-pharmacological interventions suggest a positive effect of music or music therapy on agitation (Hulme et al. 2010; Kverno, Black, Nolan & Rabins 2009; Livingston et al. 2014; McDermott, Crellin, Ridder & Orrell 2013b; Spiro 2010; Ueda, Suzukamo, Sato & Izumi 2013; Wall & Duffy 2010). Among these, the health technology assessment by Livingston et al. (2014) included 160 studies of sensory, psychological and behavioural interventions for managing agitation in older adults with dementia. From this vast material the researchers concluded that the following five interventions reduce agitation in care home dementia residents: person-centred care, communication skills and Dementia Care Mapping (all with supervision) as well as sensory therapy activities and structured music therapies. Furthermore, the researchers added that future interventions should change care home culture through staff training.

Discussion: interdisciplinarity and knowledge mobilisation

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

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

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

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

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

Following this, direct music therapy practice will consist of:

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

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

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

Conclusion

The common goal for the dementia field is to advance and develop the culture of care. The music therapist may engage directly with the person with dementia through a music therapeutic intervention, or may assist other healthcare professionals, relatives or musicians in providing musical activities to build a relationship with the person with dementia, and on the terms of each

person with dementia. It is complicated to interact through mutual understanding with persons who are difficult to engage due to neurodegeneration, but if this is done with insight and knowledge we might see important and beneficial 'side effects', such as increased quality of life, less agitation and restraints, and a reduction in psychotropic medication. Music therapists, who play a role in staff training and supervision, and not only in direct music therapy practice, bring new important dimensions to how music therapy discipline is understood and how it is integrated in interdisciplinary work.

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Lecture 2

Music therapy in dementia care and neuro-rehabilitation

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

Clinical practice

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

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

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

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

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

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

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

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

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

This is demonstrated by music therapy examples from M, a musician with early onset dementia (Odell-Miller 2002). In the third year of individual music therapy, held weekly in his home, M needed help with daily living skills. His speech was often confused, agitated, unintelligible, and he was in cognitive decline; he could still sense pitch, and musical form. His musical language within improvisations appeared intact during moment-to-moment phrases, accompanying the therapist singing, with musically coherent recitative-style chords. As the therapist, I was also able to work with M and his wife musically to help her communicate with him, and to provide emotional

support. Music therapy clinical material in research studies shows how musical interventions are also effective for people with and without musical pre-skill, such as in our research study (Hsu et al. 2015).

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

Research

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

(Hsieh et al. 2012).

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

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

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

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

- Familiar songs with familiar musical structures engage N, and motivate her to participate in musical activities, often playfully with a sense of

fun. She displays a visible reduction in anxiety and agitation during sessions, and an increase in positive affect.

- Prompting and encouraging N to play the piano helps her to use and reconnect with her remaining abilities; this also encourages memory retrieval of childhood memories.
- Matching N's rhythm and pace, and then slowing down encourages N to play and interact at a slower, calmer pace. This helps to reduce her anxiety levels.
- Reading the lyrics in music books together helps N to make use of her remaining cognitive abilities, and also helps her to focus and engage in a shared activity, helping her to feel calmer and less anxious (Hsu et al. 2015).

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

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

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

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

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

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

Education

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

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

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

Conclusion

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

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

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Lecture 3

Improvisational music therapy in neurological rehabilitation

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

Music and music therapy in neurological rehabilitation

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

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

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

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

The individual's perspective in neurological rehabilitation

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

A case vignette

A 72-year old man with Morbus Parkinson was referred to music therapy by his neurologist on a neurological ward in a general hospital. In the music therapy room, the man decides to play on a steel drum, as he became fascinated by both the shape and the sound of the instrument. After an initial phase of exploration, a lively and vivid

improvisation takes shape, jointly co-created by the man and the music therapist. With mutual initiatives, sounding the depth of a broad range of dynamic and expressive qualities in metric and non-metric modes, both drive forward the music. Finally the man determines the end of the joint improvisation by setting the last tone, turning round to the therapist and commenting on the spontaneous joint music-making with the words: "I feel so lightened up!"

Music experience in music therapy

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

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

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

Autopoietic processes

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

A second case vignette

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

self-selected, recorded music versus listening to live music, performed by the music therapist:

- Their preferred music triggered the couples memories and associations. They each selected songs and musical pieces meaningful to them from Spotify or YouTube and played them to each other. In this way, they could present each other their favourite music, and share meaningful histories alongside the chosen pieces.
- In contrast, listening to live music performed by the music therapist and tailored to the couple's situational wishes and needs, was connected to the experience of an exclusive concert taking place in their living room, and the experience of living in the present.
- Improvisations by the therapist on a guitar or a kantele, a small pentatonic string instrument, enhanced the feeling of living in the present and facilitated relaxation in the couple (Schmid & Ek Knutsen 2016).

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

Why music matters⁶

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

However, the temporal organisation of music, the co-creation, coordination and synchronisation of activities are integral ingredients of social micro-processes happening in joint music-making (Hesmondhalgh 2013). They *are* features of “music’s ability to connect people” (Hesmondhalgh 2013: 117), and in turn facilitate people to connect in music in meaningful ways. They exemplify the

“mutual tuning-in in the formation of relationships, allowing for the experience of *We*, and forming the very essence of all meaningful human communication”, as the Austrian philosopher and sociologist Alfred Schütz has put it in his essay ‘*Making music together*’ (Schütz 1951: 92).

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

Closing thoughts

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

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

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

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Reflection paper

Music therapy for prevention of stress and mild cognitive impairment

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

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

Several studies point to a relationship between stress and MCI/dementia. Researchers from Albert Einstein College of Medicine in New York followed a group of 70-year old persons from Bronx (n=507). At a three-to-four years follow-up, 71% had developed mild cognitive impairment, and those who experienced high and persistent levels of stress at baseline were twice as likely to develop mild cognitive impairment than those who felt less stressed (Katz et al. 2015). In a prospective longitudinal population study 800 middle-aged Swedish women were followed for 38 years, during which 153 developed dementia at a mean age of 78 years. The researchers found that the number of

psychosocial stressors (e.g. divorce, widowhood, work problems and family illness) and long-standing distress were independently associated with the onset of Alzheimer's dementia (Johnassen et al. 2013). Those who had experienced the highest numbers of stressful events in their middle age had 21% higher risk of developing Alzheimer's dementia, and 15% higher risk for other types of dementia.

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

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

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

When is a music therapist necessary? When a

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

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

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

Roundtable presenters
Jacobsen, Trondalen, McFerran

Discussion group members
Holck, Loth, Stensæth

Moderator
Dileo

[A reflexive introduction](#)

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

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

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

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

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

Lecture 1

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

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

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

Depending on individual cultures in different

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

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

Why a music therapist?

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

In research on the effect of music therapy a holistic view of man is evident. Looking across client groups biologically, music therapy has a positive effect on pulse and blood pressure, respiration, perception of pain, lung function and agitation (Bradt et al. 2010; Bradt & Dileo 2011; Bradt et al. 2011; Vink, Bruinsma & Scholten 2011). Psychosocially, music therapy has a positive effect on mental state, depression, anxiety, psychosis, initiative and mood (Bradt et al. 2011; Maratos et al. 2009; Mössler et al. 2011). Socially, music therapy has a positive effect on social interaction, non-verbal communication, social-emotional mutuality, social adaptation and parent-child relationship (Bradt et al. 2010; Geretsegger et al. 2014). From an

existential perspective, music therapy has a positive effect on quality of life, hope and spirituality (Bradt & Dileo 2011; Bradt et al. 2011). The broad perspective of research tells us how music therapy – which we presume includes a music therapist – is relevant as it has quite a range of positive effects for many different individuals and groups with specific challenges in relation to health.

When is a music therapist needed?

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

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

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

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

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

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Lecture 2

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

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

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

Why music?

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

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

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

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

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

When is a music therapist needed?

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

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

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

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

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

Why is a music therapist needed?

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

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

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

The last phase, phase three, was the call for solidarity (i.e. social recognition, social value and life). Attending the music therapy group gave them

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

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

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

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Lecture 3

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

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

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

"Recognizing that disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full

and effective participation in society on an equal basis with others" (Point E).

"Emphasizing the importance of mainstreaming disability issues as an integral part of relevant strategies of sustainable development" (Point G).

"Recognizing the importance of accessibility to the physical, social, economic and cultural environment, to health and education and to information and communication, in enabling persons with disabilities to fully enjoy all human rights and fundamental freedoms" (Point V).

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

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

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

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

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

and requires action in those arenas.

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

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

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

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

- Creating mutually empowering conditions so that people can flourish (resource-oriented);
- Revealing the complexities of what music can help us understand (insight-oriented);
- Carrying responsibility by providing direction

and structure when necessary (supportive);

- Advocating and agitating for changes in the oppressive systems that see people in deficit and fail to celebrate the gifts of diversity (anti-oppressive).

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Reflection paper 1

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

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

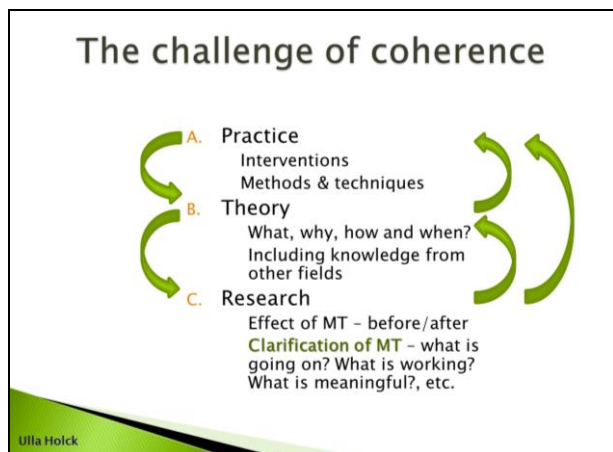


Figure 1: The challenge of getting coherence between the practice, theory and research within music therapy⁸

Katrina McFerran is referring to WHO’s conventions about the rights of people with disabilities, as well

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

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

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

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

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

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Reflection paper 2

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

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

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

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

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

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

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Reflection paper 3

Why 'why'?

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

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

When it comes to the other question (*'Why and*

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

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

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

Does my meta-perspective here really respond

⁹ See the documentary here:

<https://tv.nrk.no/program/KMTE30000614/jihad-hellige-krigere>

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

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POSTLUDE

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

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

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

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

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

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

and the Human Being], based on ideas by Even Ruud (Bonde 2011, 2016; Ruud 1998, 2016a).

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

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

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

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

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

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