



## Is Mindfulness a Useful Practice for Music Therapists? A Research Project Report

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### Abstract

*This study explores the familiarity and usefulness of mindfulness to music therapists who work in a clinical setting, and it aims to examine plausible similarities between presently known concepts of mindfulness and the conventionally established therapeutic attitude as portrayed in this paper. Seven music therapists working in London took part in this study. Four attended a focus group and three were interviewed over the telephone. The findings show that most participants were familiar with the concept and had some experience of mindfulness, and stated that it enhanced their clinical work. Participants described some practices they do to prepare themselves for sessions, and they explained how they experienced silences as well as non-musical components within music therapy. Their opinions about the familiarity of mindfulness in their profession varied. The findings suggest an overall positive view on mindfulness; however, as the sample number is small, I would suggest that my research questions and findings could be used as a platform for future research initiatives.*

**Keywords:** music therapy; mindfulness; therapeutic attitude; silence; clinical practice

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### Introduction and a summary of the literature

Mindfulness is an ancient Buddhist practice, used by Gautama Buddha during his final steps towards enlightenment (Rinpoche 2002). For simplicity and transparency purposes, it has been ‘translated’ into contemporary Western terms and has experienced great popularity in recent decades. Hanh (1987, 1991), Kabat-Zinn (1990, 1994) and numerous online resources show its popularity in general self-help as well as healthcare professions (for example, see Grossman, Niemann, Schmidt & Walach 2004; Smith, Richardson, Hoffman & Pilkington 2005).

Drawing from a range of different descriptions and definitions of mindfulness, I provide a working (composite) definition of mindfulness:

Mindfulness is conscious present-moment awareness of one’s own physical, emotional and mental disposition, as well as a non-judgmental openness to one’s surroundings. It can result in an enhanced presence to the person or task one is faced with.

Over the past years, there has been a growing body of literature that refers to mindfulness in verbal psychotherapy, and there are numerous online resources about Eastern meditation practices related to psychotherapy<sup>1</sup>. Mindfulness has been applied to Cognitive Behavioural Therapy, specifically for clients with anxiety and stress-related disorders (see Hunot et al. 2010). An additional approach to psychotherapy, which shows many parallels with

<sup>1</sup> For examples of online resources, see the web-links provided at the end of the article.

mindfulness-based therapies, has been pioneered by Stern (2004), focusing on the present moment in psychotherapy. Analysis shows that the patient's ways of thinking and acting in seemingly insignificant situations relate to more profound aspects of their lives (e.g. their career and relationships).

Stern further points out the difference between *chronos* (chronological time) and *kairos* (relative, subjective time). Arthur (2006) states that timelessness and suspending chronological time is essential for analytic work. This work, however, seems to lack the idea that it is the very awareness of the present moment that can facilitate the experience of clarity and space. This can mean that either a) mindfulness is already present in the therapeutic process but simply has not yet been identified, or that b) making therapeutic presence conscious may oppose the process in which, due to lack of spontaneity, real change can happen. While I would argue that a) is certainly plausible, I would state that b) may be based on a misunderstanding as, once applied and grown used to, an active application of mindfulness would enhance the therapeutic process and the relationship rather than hinder it. It could be applied either through verbal or musical elements, or both at the same time.

Despite the growing interest in the relevance of mindfulness to psychotherapy, very few authors have discussed the relation of mindfulness in music therapy thus far. Among them, in his doctoral dissertation, Fidelibus (2004) explores how musical improvisation can be used as a means to enter a state of mindfulness. On the other hand, Bruscia (1987) writes that amongst the personal qualities of the therapist are respect for the client, warmth, sensitivity and empathy. Most of these qualities could be said to be acquired through mindfulness practice, which fosters non-judgmental presence and unconditional love. Lomas (1994) does not relate therapeutic attitude to mindfulness and Eastern wisdom, but to psychoanalytic practice, as based on Freud's findings. He further describes qualities desirable for a therapist, which compare closely to Bruscia's ideas.

Within the clinical setting of music therapy, the aforementioned definition of mindfulness could be adapted as follows:

Mindfulness is the therapist's conscious present-moment awareness of his/her own physical, emotional and mental disposition, as well as a non-judgmental openness towards his/her client(s). It can result in an enhanced presence to the development of the session.

## Research aim

Drawing from the literature as well as my own experience of practicing both music therapy and mindfulness, I would argue that music therapy seems to own numerous elements of mindfulness, without necessarily making it a separate practice. Motivated by my interest to ground my argument in empirical research, I conducted this study which explores whether mindfulness is a useful tool for music therapists and how it can be applied clinically.

## Methodological framework

I invited 100 fully registered and currently practicing music therapists resident in London to participate in my study. Music therapists were selected randomly from the British Association for Music Therapy (BAMT) directory of members 2010-2011. Out of all invitees, eight replied. Four of them attended a focus group and three were interviewed by telephone. Telephone interviews lasted between 25-50 minutes (see Table 1). The focus group lasted 80 minutes. Both focus group participants and telephone interviewees were asked to discuss the same set of semi-structured questions.

	Participants	Date of data collection	Length of interview / group discussion	Professional experience (client group/setting)	Previous experience of mindfulness practice	Personal practice related to mindfulness
Telephone interviews	T1	26.03.2011	52mins	Older adult mental health	Yes	Yes
	T2	29.03.2011	25mins	Dementia / Community music	Yes	Yes
	T3	26.03.2011	36mins	Neuro-disability	Yes	Yes
Focus group	F1	30.03.2011	1hr 20mins	Adult hospice	Yes	No
	F2			Autism	No	Yes
	F3			Special needs children	No	Yes
	F4			Special needs children / Community music therapy	No	No

Table 1: Data collection and sample

The group was heterogeneous in terms of age, gender, nationality and professional experience. For reasons of confidentiality, participants' identity is encoded. Telephone interviewees are named T1, T2 and T3, and focus group participants are named F1, F2, F3 and F4 respectively. Data collected both from the telephone interviews and focus group were analysed thematically.

## Findings

The findings from telephone interviews and focus group discussion are presented below following the structure of the original interview schedule. The themes emerging from the findings are further explored in the discussion section.

### How do you prepare yourself for a session (i.e. how do you acquire a therapeutic attitude) and what do you do to reflect on the session afterwards?

All three telephone interviewees described a way of preparing themselves for a session of clinical work which included becoming physically still and trying to calm the mind so that they could meet the patient with an open, non-judgmental mindset. T1 in particular described a technique which he referred to as 'the practice'. He uses it to become aware of his physical sensations, in particular his sense of hearing. He also thinks about a certain unity, or connectedness with everyone and everything, as well as the aim to let go of any expectations and anxieties.

T1: There is a possibility [...] that one might meet the client almost like the first time. [...] There is an openness that a new path might be found in that session, rather than to expect that it will be a repeat of previous sessions.

T1 and T3 described a focus that includes their own physical, intellectual and emotional states. When asked whether she used any exercises from her personal practice in sessions, T2 stated the following:

T2: [...] in a still moment [I might] be aware of my breathing, but the focus is definitely on the other person, I totally zone into the other person. [...] but] I don't try to experience what they are experiencing; I don't try to swap roles. It's about being so empathetic that you are not even thinking. You are almost breathing with that person, operating together.

So while there was much focus on entering a conducive mindset before a session, my three interviewees described very little of what they would do to let things settle afterwards. T3 described a short period of reflective time, doing

paperwork with her assistant after holding a group. T1 explicitly said that his mindfulness practice was for preparation – "I would be unlikely to do it afterwards".

The focus group participants discussed this question too. F2 stated to make "conscious effort (to) seek some sort of strong awareness", spending at least half an hour before her session to focus and become present to her work. F4 stated that sometimes he found himself quite restless before a session, until he would become aware of this, and then he played the guitar to ground himself.

F3, in contrast, said she now only had 10 minutes between sessions in her work during weekdays, which included returning a child from class and preparing for the next session. However, she regards her daily Buddhist practice of chanting as part of her preparation for what she might face during a day of clinical work. Once per week however she sees an adult patient for whom she has more preparation time:

F3: ...because he is first, I do have a chance to prepare. He can get quite anxious so I often feel anxious too, so I warm up my voice to ensure that the first time I use my voice on that day is not with him in the room, but that I discover what my voice sounds like before that. I also do a physical warm-up, to shake some of the tension out of my body.

For F1, preparation was more a matter of becoming present to musical interaction with a client through listening. This sometimes had to happen almost instantly as he was working several days a week in a hospice, where therapeutic boundaries were not as strictly held and a music therapy session could be arranged very spontaneously:

F1: I may come across someone suddenly and we say 'ok, let's do music', although the session was not planned. There is [no] time for preparation, so I am tuning in immediately with basically just listening.

This is an exceptional situation within therapeutic boundaries and puts extra demand on the therapist's ability to prepare very quickly.

Some discussion followed about how much music therapists needed to keep their patients in mind beyond a session, as this relates to being mindful of someone. F2 shared with the group that she often used the time driving back from her session to listen back to the recording. F4 then jokingly said that "you need to dedicate one dream per night to a client", illustrating an extreme case of holding someone in mind beyond the therapeutic framework. I will discuss in the following section that this does not directly apply to mindfulness as present moment awareness. F4 then shared with the

group that, for a while now, he was so immersed in the ‘here-and-now’ of the session, that only afterwards he realised some of the dynamics, such as repetitive, symbolic play.

F4: I could have said something there and then, [commenting] on the behaviour. I am sure that with experience and [with sensitivity and openness, one] can work it out there and then. Is that not mindfulness, being very focused and attentive to putting the little pieces together?

F3 then encouraged him by saying that mindfulness could “happen at different speeds”, and that the most important thing was the therapist’s willingness to understand, rather than to have an insightful realisation immediately. This is another example of mindfulness becoming a very general term in the focus group discussion.

#### How do you experience silences?

Each participant of the telephone interviews stated that there were different kind of silence, and that some happened for very simple reasons, e.g. the cognitive impairment of some clients – T3 stated that this was “the main clinical reason behind silence” in her work. T2 pointed out that she would not normally break a silence but let the patient experience it, as it was a very important part of the music; however, if the client had special needs or was feeling very vulnerable, she would “say something comforting or encouraging”. T1 was equally positive about silences:

T1: I think in those gaps things can come up, and eventually the client will want to fill the silence with something significant. But if one is constantly filling the silence with noise that doesn’t really allow for that. Especially with our clients whose brains are working a little bit slower than ours.

Further investigation showed that there were certain individuals for whom silences were not particularly conducive:

T1: It depends on the client group. If someone is left with too much silence they won’t do very much, so we have to offer a lot as a therapist. [...] Silences depend a great deal on where people are [in their mind-set], whether they can offer something or whether they need you to complete them so that they can be as fully present as possible at their stage of illness.

Returning to focusing on how silences can be used by the music therapist, T3 shared the following thoughts:

T3: I try to use silence to become more aware of what is going on, to scan the room i.e. to see [how] people are [...]. I also use silence to check in with myself, whether I am rushing, [or] whether I could push along the momentum. I use silence outwardly and inwardly – now I really enjoy silences!

Participant F3 of the focus group stated the following: “There are [...] many different kinds of silences [...]. It depends on the relationship”. F3 explained the difference in experience between different silences. In some cases it may mean a great achievement that a patient can be silent in a session, i.e. a sign of trust. Other silences, such as the silence of a child with selective mutism, can be horrible:

F3: I know if I say something I won’t get a verbal response, or even a vocal one. Those silences can be really oppressive. But the child’s difficulty of communication perhaps transfers itself.

F1 described a “gut feeling” which could tell him when it was a good moment for both patient and therapist to move on from a silence into something new. However, he also remarked that when thinking of silence he would typically think of prolonged silence, but there was also significance in very short silences, such as a pause in music. However, we did not further explore the difference between musical and verbal silences.

#### How much do you refer to non-musical elements such as breathing, movement or any emotional presentation when relating musically to your client, especially if they do not play or sing?

T2 related a piece of clinical work with a young man who was quadriplegic. She described her emotional and subsequently musical response to him as follows:

T2: I found myself being quite nurturing in the music I played. [One’s] music is quite individual anyway, but I found myself playing him very beautiful things. There was so little to go on and I did find that quite hard. [...] But my feelings towards him may be influenced by myself being a mother and having grown-up children, so I couldn’t separate what came from my experience as a mother and what came from him, and how I related to him.

T3 stated that she “definitely” used the non-musical elements:

T3: I look at all the responses of my patients. The musical ones are just part of it, although I will meet them musically. Some people don’t

respond musically at all, but these are still very valid responses.

She further stated that she used breath as a natural rhythm to reach states of entrainment, especially with low-awareness patients and only in individual sessions. At this point I brought awareness to the thought that breath was an important component of music-making in terms of structure and style, but that it was also a key tool for mindfulness practice.

Responding to the same question, T1 agreed that the non-musical components of the musical interaction were “essential”, and “all part of the communication”: “The movement is part of (the client’s) musicality, and the way we breathe is the music of the body in music therapy.”

In the focus group, people had been discussing in detail the intellectual side of mindfulness, i.e. keeping the patient in mind as well as the awareness of thoughts and feelings in response to what the patient brings. However, little awareness had been shown in regards to the physical and sensory component of mindfulness, thus I brought my participants’ attention to it after some 45 minutes. I acknowledged that the term ‘mindfulness’ may be misleading, and F1 later described it as follows:

F1: It is called mindfulness, but actually I think it is body-soul-social-fulness. It includes the body, psyche, spirit, mind, music-fulness. It is all that!

I prompted the thoughts that, in music therapy, mindfulness could be related to listening and the quality of musical elements such as rhythm, timbre and harmony etc., as well as breathing and movement. I hinted at the fact that the latter components were particularly important with clients who play little or no music, in order to focus the discussion on how non-musical elements, mainly of a physical nature, would inform the way a music therapist would improvise with and for their client. F2 mentioned her own research about the significance of register, which partly implied that music had a sensory importance for some clients:

F2: Regarding the physicality of mindfulness, I wonder whether the physicality of vibrations and overtones also resonates and makes another aspect of mindfulness?

Somehow this question found little resonance with the group. They did, however, discuss how changes may arise in the music and that these can be closely linked to a client’s mood or to the therapist’s openness.

F4: I think about how many times I have been bored with my own music in sessions. The moment when I get lost or immersed something new emanates from me...

F3: Something else becomes possible.

F4: Suddenly I find a new chord. It is not out of space but very much linked with a newness about the client.

F3 further mentioned a ‘physical barometer’ that suddenly made her aware of her own physicality, especially with children who had physical disabilities: “It helps me notice when I am not matching someone’s movement too well”.

#### Have you heard much about the use of mindfulness in healthcare professions in general?

This question was only discussed in the telephone interviews, and triggered perhaps the greatest discrepancy amongst my interviewees: T1 and T2 were not very aware of the clinical applications of mindfulness in related healthcare professions. This may be because at their respective workplaces (care homes for older adults), they are not as connected to other professionals. T3 had heard about it a lot at her work place and had a critical attitude towards it. She had encountered advertisements about training in mindfulness-based techniques, and was aware of various research results around this topic. She does, however, regret that it was merely used as a clinical technique for problem-solving, while in her personal practice the emphasis was on its spiritual dimension. “(This use of mindfulness) takes something away, and that is a shame. But if that is what makes sense to people that is OK.”

#### Have you got any experience of mindfulness practice?

This question was only discussed in the focus group. F1 has some experience of mindfulness, mostly through music-making:

F1: My experience of mindfulness is very personal. I have not studied it or been part of a group exercising it. I relate it very much to spirituality though not to religion. [In] my definition, we all experience mindfulness at different times on different levels, so I [...] have experienced it, but not in terms of [...] being in a quiet room meditating, but by playing music with somebody or walking down the road.

F2 expressed great interest in mindfulness and has read about it. She has further thought about its application in different settings of working with people: “For me it is about being self-aware and present in the task you are doing.”

F3 is a practicing Buddhist, but has not practiced mindfulness deliberately. However, her therapeutic attitude is very closely linked to it:

F3: I have not come across (mindfulness) before... although I am a practicing Buddhist. As I read your starting definition (via email), I realised these are all things I try to do, just being in there 100% with the client and not letting myself be drawn to any noises that are going on outside etc. I just really try to stay in the present moment with the client and to respond to them as they are now. I think that is something I do my best to practice.

Similarly, F4 had no direct experience of practicing mindfulness, and raised the question at the beginning whether it had Buddhist roots or whether it was a purely psychological concept. He has thought in detail about conscious awareness in a clinical context:

F4: "...sometimes there is a session when things click – we can go somewhere, we dream together, I forget – I become absent-minded in the sense that I am not thinking, I'm just there playing, and after the session I feel wow, that was beautiful! And those kinds of sessions make me feel that I want to continue the work.

Some participants also valued mindfulness for enhancing their ability to make the right intervention. F3 stated that it helped her to hold in mind the overall aims for a client, especially at challenging moments. F4 put the question to the group whether mindfulness also aided self-acceptance: "Maybe mindfulness means being able to be yourself with the anger, the frustration, lack of caring, resentment – but being aware of it and everything." He further shared a prejudice that he held against Buddhism, of "nothing can touch me because I am so self-contained". We agreed that this was a dangerous misconception about mindfulness, and that in a therapy setting we had to be aware of our emotional responses, being present to the client rather than removing ourselves.

#### Do you consciously use any mindfulness practice as part of your clinical work?

This question was only discussed in the telephone interviews. T2 expressed that even without the use of mindfulness, music therapists had to apply a higher sense of awareness in their clinical work "than the average person". However, she appreciated mindfulness for the fact that it helped her settle, which meant that instincts and intuition were more centred. "It is such a simple, powerful concept, and that has surely fed into my music therapy sessions." Once she found a way of being

settled through mindfulness she felt an enhanced ability of being with a person, even in silence, "free to be still... before you start leaping into sound". She stated this to be "part of the realisation that we are all connected – a living presence of sharing in this life at this moment".

T3 stated in a similar way that her personal practice had made her more conscious and sensitive in her responses. This stands in slight contradiction with her initial statement:

T3: I am a practicing Buddhist, so mindfulness and meditation are an important part of my personal life, but I don't think so much about it within the therapeutic application of my work. That is why I was interested in your project.

She later described a way of 'checking in with herself', through which she becomes aware of her physical and emotional states. This was important to her as it made her "more responsive to what might be going on for the patient." "It slows me down internally and I am more in touch and in the moment".

T1 agreed to my prompting statement that mindfulness could be "helpful as a tool for the more difficult days". He said not only could it help a music therapist to be better prepared for what a session might bring, but it also helped him to make clinical decisions during a session. He mentioned clients who were affected by dementia, and that some of their play could be very perseverative.

T1: Mindfulness is also a constant balancing act of what we are going to go with and where we can do something different. (...) But only by being mindful can you make the most useful choice.

Apart from being present to the client(s) and making conducive decisions within complex group dynamics, T1 further appreciated mindfulness as a way of making a meaningful connection with his clients:

T1: We are looking for a spiritual communication, really. (...) We as therapists have to trust that the spirit we are trying to connect with is receiving something from us. Even a damaged human being has a core that is still intact and there is a possibility of contact with that.

He further stated that mindfulness could help a music therapist to attune, and further to meet the challenges of being exposed to so much neurosis: "You have to have something to keep you sane."

## Discussion

Drawing on my research findings about mindfulness and its importance for a restricted number of music therapists currently working in London, in this section I will discuss and further explore these findings.

During the telephone interviews and the focus group, various definitions of mindfulness practice emerged, as well as situations in which mindfulness is particularly helpful or especially difficult to maintain. As a starting point, I would like to repeat the initial composite definition that I used to introduce my research:

Mindfulness is the therapist's conscious present-moment awareness of his/her own physical, emotional and mental disposition, as well as a non-judgmental openness towards her client(s). It can result in an enhanced presence to the development of the session.

During the interviews and focus group discussion however, participants explored mindfulness in relation to different aspects of music therapy practice that do not directly relate to the aforementioned definition. Therefore, I would like to consider putting mindfulness into a different context when used within clinical music therapy. I would also like to draw attention to the fact that although almost all the participants follow a personal practice in which mindfulness plays a key role, such as meditation or yoga, not all of them regard it as defined above. Thus in this section I point out when the conversation drifts off into a different realm of practice.

Below, the research findings are further explored and related to existing literature where relevant, according to the following emerging themes: a) preparation, b) reflection, c) benefits of using mindfulness, d) perceptions of mindfulness, e) challenges to mindfulness, f) mindfulness in relation to psychodynamic thought, and g) a definition of mindfulness within music therapy.

### *a) Preparation*

T1, T3, F2 and F3 each described a way of becoming aware of their disposition by focusing their awareness on physical sensations such as breathing and any arising tensions, as well as the quality of their listening. F3 was the only one who described a physical warm-up of shaking her limbs and warming up her voice, and F4 was the only one who shared an experience of feeling grounded by playing the guitar when he found himself feeling restless before a session. While the awareness of breathing is a key exercise to enhance mindfulness (see Hanh 1991), a vocal warm-up or guitar practice may not traditionally count as mindfulness

practice but, like almost any action, it can be performed in a mindful way.

Most interviewees and participants thus described ways of becoming aware internally and externally of themselves, which is in accordance with the definition of mindfulness that I have provided above. This features one of the key aspects of mindfulness, namely a balance between internal and external presence. Chris Cullen, who teaches the module "mindfulness for musicians" at the Guildhall School of Music and Drama (GSMD), refers to this as '50-50 awareness'. This is highly relevant to music therapy, as a clinician is required to be aware of his thoughts and emotional responses, especially in the case of a counter transference, but he also needs to be very open-minded and perceptive in regards to his client. However, F2 stated that her focus was very strongly on the other person. I believe that this is a result of extended clinical experience and an ability of effortless self-awareness, so that the patient can take up a majority of the therapist's focus without the therapist being unaware of herself (which, of course, would be counter-productive).

### *b) Reflection*

T3 mentioned time for reflection when doing her paperwork after a session. F2 stated that she listened back to her session when driving back home. F4 shared that reflection time was very important for him as currently some of the insights only came to him after the end of a session. Other than that, participants seemed to use mindfulness practice during preparation time rather than after a session. According to Yalom (2002), taking time between patients to write notes, which he will then refer to in the subsequent session, is a crucial part of the practice. It is meant to allow the therapist to be present to any remaining thoughts and feelings after the client has left, and take time making sense of them to optimise the patient's development.

### *c) Benefits of using mindfulness*

There are various qualities that music therapists (and indeed other types of therapists) are generally expected to have, that are said to be enhanced by mindfulness:

T2 stated that mindfulness enhanced her sense of awareness, so her instinct and intuition were stronger. This also enhanced the quality of silences in her sessions. In a similar way, T1 said that it helped him to make conducive decisions during a session, especially when facing the complexity of group dynamics. He later mentioned that mindfulness enhanced his ability to become attuned to a patient, thus helping to establish a therapeutic relationship. He also appreciated that mindfulness

helped him to maintain good mental health in the face of challenging client groups.

F4 said he valued mindfulness for giving him the ability to be sensitive and attentive to his clients' experiences, and ideally to be able to make an intervention at the right time. However, he shared with the group how he sometimes struggled to see clearly what was happening in a session, and wondered whether mindfulness could also be paired with self-acceptance, as the awareness of one's own difficult feelings may enhance clinical practice. F3 stated that in difficult moments, when her benevolent attitude (unconditional positive regard as defined by Rogers 1961) towards a client was at threat, mindfulness helped her to remember why this person needed her support and understanding.

A particular aspect of being in the moment is total immersion, often referred to as a peak experience, which was mentioned several times in the focus group discussion. F1 initially expressed that a state of mindfulness did not have to lead to a peak experience, but that it was a realm that one could enter for a prolonged period of time. However, later on, the group discussed moments of "getting lost in the music" as a result of being very open and present during clinical work. This was said to facilitate a heightened sense of connection between client and therapist. It was described to usually happen in the music, but F4 in particular said it could also happen on a verbal level, yet music was a very valuable catalyst for this experience. F1 agreed that music was not the only way of reaching this realm, but that it could be of great help. Fidelibus (2004) presents clinical improvisation as a tool to focus on the present moment and to share this mind-set with the client. The emerging awareness may be comparable to a meditative state, in which therapeutic communication through music is enhanced. Fidelibus also mentions that the therapist's awareness is not only on the client, but also on herself. This can support mindfulness being a useful tool for music therapists.

The scope of this discussion does not allow me to fully explore the psychological complexity of a peak experience as defined by Maslow (1994), yet in this context I believe it can be caused by a state of strong present-moment awareness, so a new path can be found within the clinical framework, such as a new musical modality, e.g. change of key or rhythm. F4 shared that this would usually happen after a sense of letting go of any expectations or reservations, such as an anxiety of what may happen next. This is in congruence with T1's belief that mindfulness can aid to make a beneficial decision spontaneously during clinical work, perhaps one that is more therapeutic than staying with what is already happening. However, this new realm cannot be reached by control, but rather by

decoding even very subtle cues from (a) client(s), such as non-musical elements. The latter have communicative importance during clinical improvisation and the forming of a therapeutic relationship. As with other concepts, focus group participants agreed in particular regarding the subject of immersion that grasping at a certain concept was detrimental to authentic experience. As much as it was important to be very familiar with the theoretical aspects of music psychotherapy, a clinician had to be spontaneous and open during her work. T2 shared with me that her aim was to stop thinking when she was with a client, for the purpose of being very focused on and present to the individual. As discussed above, this aim perhaps is a result of very diligent theoretical studies, so that the concepts could be internalised and spontaneously available during clinical work. It is most likely that she meant to stop thinking about issues of the past or future, and to be fully present with the client.

#### *d) Perceptions of mindfulness*

F3 asked me via email to give a starting definition before the focus group took place, so I provided her with a definition similar to the one above. At the beginning of the group discussion, F4 asked whether mindfulness was Buddhist in its roots or whether it was merely a psychological concept. I confirmed both, stating that currently in healthcare professions I observed a tendency towards the psychological aspect, as giving it a religious or spiritual connotation could easily evoke scepticism. This has also been a point of discussion in my telephone interviews, in particular with T1 and T3 who expressed regret about mindfulness missing a spiritual component. F1 declared that he would pair mindfulness with spirituality though not with religion.

#### *e) Challenges to mindfulness*

Some contexts were identified in which mindfulness was not the most useful approach. Also, it might have been found that keeping to a particular concept might jeopardise the music therapist's authenticity (see above also). F1 and F4 expressed criticism towards using preconceptions and terminologies as these may restrict a therapist's versatility. While T1 simply stated at points that e.g. psychodynamic thought would also be a useful way of tackling a certain clinical challenge, F3 and F4 agreed that at times they simply worked developmentally, and that mindfulness would not be the most conducive approach. This was said to be the case for music therapy in schools, where children were referred to enhance their social abilities such as turn-taking and awareness of self

and others. Of course, the therapist has to be present-minded, but mindfulness was not their chief clinical tool.

Another misconception seems to be caused simply by the term 'mind-fulness' as it seems to imply a strong focus on intellectual activity. F2 related it closely to psychodynamic thought, as it implied a 'keeping-in-mind', while F1 said it was "body-soul-social-fulness, including the psyche, spirit, mind and music". It may be that the word 'mind' is generally understood as the brain and intellect, whereas from a more holistic viewpoint, it can include dreams and emotions, and can even be linked to physical sensations and activities, in the sense that body and mind are closely linked or even part of the same entity. My telephone interviewees did not display that same misconception, but in my focus group I had to point out the importance of physical awareness after about 45 minutes.

F3 equalled mindfulness to insight, when stating that it could "happen at different speeds", i.e. a therapist could not always see things clearly the moment they emerged. This relates to reflection, unless the insight happens during the session as a result to enhanced presence to what is happening in the moment. Participants found that this would be the ideal case, yet it could not be expected at all times.

F2 equalled mindfulness to holding the patient in mind after a session, a misconception that was probably caused by 'mind-fulness' being a misleading term, as discussed above. She related this to psychodynamic thought, raising the question of how much thought a therapist needs to give to a client beyond session time (see also Yalom 2002). This question was not clearly answered by the group, but I would like to note that this topic does not closely relate to mindfulness as present-moment awareness, as it considers engagement with the client when they are not physically present, so the internal and external awareness become unbalanced.

#### **f) Mindfulness in relation to psychodynamic thought**

At different points during interviews and the group discussion, participants related mindfulness to psychodynamic thought. To T1, it was a system, a way of decoding through which one could make sense of clinical work, in the same way as mindfulness is a system of thought. As discussed above, F2 related it to 'keeping in mind', which she related to psychodynamic therapy. This shows that the two systems get referred to by music therapists, and that mindfulness has a clear place within clinical work for some of my participants. It is also in accordance with the belief that clinical work aids itself with these concepts, rather than needing to

fully conform. This strengthens the eclectic approach that was generally presented by my participants, in which mindfulness has an important place and gets referred to as and when clinical practice demands this.

#### **g) A definition of mindfulness within music therapy**

As stated initially, mindfulness needs to be defined more specifically in relation to music therapy. I have discussed its clinical use regarding its strengths and challenges, exploring its usefulness within clinical practice, highlighting any misconceptions that emerged from my interviews and group discussion. I would now like to provide the following definition of *mindfulness for music therapists in a clinical setting* (based on the initial definition provided earlier on):

Mindfulness is the music therapist's conscious awareness of his/her physical, emotional and intellectual disposition balanced with a non-judgmental perception of and openness to the client's musical and non-musical communication, paired with the ability to spontaneously and mindfully make an appropriate clinical decision in accordance with the client's emotional presentation and needs.

#### **Conclusions and implications for future research**

My findings show that some music therapists do apply mindfulness to their clinical work, and have drawn great benefit from this. Especially in the focus group, some confusion emerged about a clear definition of mindfulness, so it was, at times, confused with related topics such as *keeping in mind* or *gaining insight* into a clinical situation.

The initial response to my research invitation was very low (8 out of 100 music therapists responded to my invitation to take part in this research), which may indicate that mindfulness is not widely applied in music therapy. A greater number of participants would have perhaps generated more varied data, including criticism of the concept of mindfulness. I have, however, gained insight into the terminology currently used, and how practitioners think about the clinical application of an ancient and, in many aspects, spiritual tradition.

The study's findings can function as a platform for further research. A future step would be to use these findings to design a questionnaire that can be distributed widely, so that further data can support knowledge about how mindfulness could be introduced to clinical practice. The current research question focuses on how music therapists can

enhance their clinical work through the application of mindfulness, but further research is needed to investigate how patients can benefit from this, and how mindfulness techniques could be introduced to music therapy sessions on a practical level between therapist and patient. Questions may also arise as to what extent this would be possible, taking into consideration that the practice of mindfulness requires a relatively high level of cognitive ability, but a great part of client groups in music therapy face different conditions, including cognitive impairment.

I hope that this study can support and inspire further research, and that a fusion of mindfulness practice and the therapeutic attitude can help to further inform clinical practice within music therapy. The latter invites a technique to balance internal and external awareness, and I hope to have made an initial step towards applying this ancient practice within the context of clinical music therapy, by presenting how it is currently viewed by a small number of music therapists in the UK.

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### Web-links

- The Centre for Mindfulness Research and Practice, School of Psychology, Bangor University, [www.bangor.ac.uk/mindfulness](http://www.bangor.ac.uk/mindfulness)
- Mindful Based Cognitive Therapy, <http://mbct.co.uk>
- Mindfulness, Mental Health Foundation, [www.bemindful.co.uk](http://www.bemindful.co.uk)

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