APPROACHES

An Interdisciplinary Journal of Music Therapy

Ένα Διεπιστημονικό Περιοδικό Μουσικοθεραπείας

Contents | Περιεχόμενα

CONFERENCE REPORTS

EDITORIAL

Toward theory-informed clinical research and practice

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Over the years, *Approaches* has nourished my intellectual curiosity by giving me opportunities to access material that reflects international and diverse perspectives in music therapy and related professions. I first joined the *Approaches* team as a peer reviewer in 2011, and in 2017 I stepped into the role of associate editor. The experience of serving as associate editor has been rewarding by allowing me to engage in a dialogue between authors and reviewers, and thus supporting publications that enrich the knowledge pool of our profession. While it is my honour to write this editorial, it is also bittersweet, as I will be stepping down from my role as associate editor this December. My commitment to *Approaches*, however, continues, as I will carry on contributing as a member of the advisory editorial board.

In this editorial I bear witness to how much the scope of *Approaches*, as an open-access journal, has grown over the past years. In my opinion, this issue reflects an emphasis grounded in clinical work that is informed by diverse perspectives bringing together music therapy and related disciplines. Specifically, the authors of articles published in this issue provide readers with theoretical insights and answer research questions rooted in clinical practice. This translation of theoretical issues into research that informs clinical practice aligns with what Stige (2015) identified as a key turn in music therapy – emerging research productivity that is contextually relevant.

Research focusing on intentionality, through which a therapist can use their personal qualities within the boundaries of ethical practice, is contextually relevant for clinicians despite what theoretical lens informs their clinical work. In this issue, Ahonen discusses how a therapeutic relationship develops when "music therapists equally use both music and their own person" in order to bring forth therapeutic change, a concept infrequently addressed in music therapy literature. In the manuscript the reader can learn about clinical issues such as being a wounded healer (because our own experiences allow us to empathise and better understand others), managing countertransference, and understanding vicarious traumatisation (which occurs through repeated exposure to client traumatic disclosures). Those aforementioned clinical issues prompted Ahonen to

conduct an exploratory survey into how Canadian music therapists engage and reflect upon use of self in the therapeutic relationship.

Also providing information that is contextually relevant in their manuscripts, Ramaswamin and Silverman, as well as Lim, reflect on applying theory to provide a support frame for specific clinical interventions. In order to develop a neuroscience-based rationale for patient-preferred live music (PPLM) as a receptive intervention, Ramaswami and Silverman conducted a literature review. Their review benefits our profession by increasing our understanding of the mechanism through which music-listening brings forth neurobiological changes, which then in turn change our behaviours and affect. Aspects of music-listening as a neurologic reward, as offering a sense of familiarity and preference (that allow a sense of control and effective distraction), choice and autonomy in selecting music, as well as the social component of music-making, become the proposed theoretical pathways supporting live music as a receptive music therapy intervention. Lim, on the other hand, applies Egan's Helping Model to explain both theoretical and empirical questions pertaining to clinical work with individuals with substance-abuse disorders. The specific theory is illustrated through a case study that includes assessment, clinical goals, and discussion of specific music-based experiences.

Reflecting the interdisciplinary nature of the journal, Keramida and Vaiouli write about differentiated teaching approaches in music education. A collaboration between researchers blending their training in special education, music therapy and music education, their article provides a phenomenological in-depth analysis of challenges in addressing the educational needs of children with special needs in elementary general education classrooms.

The systematic investigations of diverse clinical issues make the articles in this issue culturally and scientifically relevant. The theoretical insights in these manuscripts can translate into direct clinical practice applications. The book reviews included in this volume also reflect the surge in understanding research, using research to inform clinical practice, and engaging in inter-collaborative activities. Similarly, the conference reports represent interdisciplinary dialogue between musicologists, music educators, special needs educators, psychoanalysts, and music psychologists. It is my hope, as associate editor of *Approaches*, that the four articles included in this issue, as well as the plethora of book reviews and the conference reports will ignite our readers' intellectual curiosity and provide both relevant and inspirational material.

Closing this editorial, and on behalf of the whole team of *Approaches,* I would like to express our gratitude to our Advisory Editorial Board members who are approaching the end of their five-year service on the journal's board and will be stepping down by the end of the year: Anthi Agrotou, Mitsi Akoyunoglou, Cochavit Elefant, John Habron, Efthymios Papatzikis, Maria Pothoulaki, Hanne Mette Ridder, Shirley Salmon, and Melanie Voigt. We thank each and every one of them and convey our deep appreciation for their enormous contribution to *Approaches* over the past years. At the same time, a warm welcome to the new team members who joined our Advisory Editorial Board over the past months: June Boyce-Tillman, Enrico Ceccato, Tali Gottfried, Steven Lyons, Raymond MacDonald, Beth Pickard, Vassiliki Reraki, Lorna Segall, and Anita Swanson.

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ΣΗΜΕΙΩΜΑ ΣΥΝΤΑΞΗΣ

Προς μια θεωρητικά τεκμηριωμένη κλινική έρευνα και πρακτική

Βαρβάρα Πασιαλή

Queens University of Charlotte, ΗΠΑ

ΒΙΟΓΡΑΦΙΑ ΣΥΓΓΡΑΦΕΑ

Η **Βαρβάρα Πασιαλή**, PhD, MT-BC, είναι Επίκουρη Καθηγήτρια Μουσικοθεραπείας στο Queens University of Charlotte και μελετά θέματα πρόωρης παρέμβασης, ανθεκτικότητας, και οικογενειακά-βασισμένης θεραπείας. Βασικές περιοχές της διδασκαλίας της συμπεριλαμβάνουν τις μεθοδολογίες έρευνας, τον αυτοσχεδιασμό, τις εφαρμοσμένες κλινικές τεχνικές, και την ψυχολογία της μουσικής. Η Δρ. Πασιαλή παρουσιάζει τακτικά τη δουλειά της σε συνέδρια και έχει δημοσιεύσει σε ποικίλα περιοδικά. [pasialiv@queens.edu]

Μέσα στα χρόνια, το *Approaches* έχει τροφοδοτήσει τη διανοητική μου περιέργεια προσφέροντάς μου ευκαιρίες πρόσβασης σε υλικό που αντικατοπτρίζει διεθνείς και ποικίλες προοπτικές στη μουσικοθεραπεία και σε συναφή επαγγελματικά πεδία. Εντάχθηκα για πρώτη φορά στην ομάδα του *Approaches* ως ομότιμη αναθεωρήτρια το 2011, και το 2017 ανέλαβα τον ρόλο της αναπληρώτριας συντάκτριας. Η εμπειρία μου ως αναπληρώτριας συντάκτριας με έχει ανταμείψει δίνοντάς μου τη δυνατότητα να συμμετέχω στον διάλογο μεταξύ συγγραφέων και αναθεωρητών και ως εκ τούτου να υποστηρίζω δημοσιεύσεις που εμπλουτίζουν τη δεξαμενή γνώσης του επαγγέλματός μας. Αν και είναι τιμή μου να γράφω αυτό το σημείωμα σύνταξης, είναι επίσης γλυκόπικρο, καθώς θα παραιτηθώ από τον ρόλο μου ως αναπληρώτριας συντάκτριας αυτόν τον Δεκέμβρη. Ωστόσο, η αφοσίωσή μου στο *Approaches* διατηρείται, καθώς θα συνεχίσω να συνεισφέρω ως μέλος της συμβουλευτικής συντακτικής επιτροπής.

Σε αυτό το σημείωμα σύνταξης, παρατηρώ την ανάπτυξη του πεδίου δράσεως του *Approaches* ως περιοδικού ανοικτής πρόσβασης με την πάροδο των τελευταίων χρόνων. Κατά τη γνώμη μου, αυτό το τεύχος αντικατοπτρίζει μια έμφαση βασισμένη στην κλινική εργασία η οποία ενημερώνεται από ποικίλες οπτικές γωνίες συνδέοντας τη μουσικοθεραπεία με άλλους συναφείς κλάδους. Συγκεκριμένα, οι συγγραφείς των άρθρων που δημοσιεύονται σε αυτό το τεύχος παρέχουν στους αναγνώστες θεωρητικές γνώσεις και απαντούν σε ερευνητικά ερωτήματα που έχουν τις ρίζες τους στην κλινική πρακτική. Αυτή η μετάφραση θεωρητικών ζητημάτων σε έρευνα που ενημερώνει την κλινική πρακτική ευθυγραμμίζεται με αυτό που προσδιόρισε ο Stige (2015) ως μια βασική στροφή στη μουσικοθεραπεία – μια αναδυόμενη ερευνητική παραγωγικότητα που είναι σχετική με το πλαίσιο αναφοράς της.

Η έρευνα που επικεντρώνεται στην πρόθεση μέσω της οποίας ένας θεραπευτής μπορεί να χρησιμοποιήσει τις προσωπικές του ποιότητες εντός των ορίων της ηθικής πρακτικής είναι σχετική για τους επαγγελματίες ανεξαρτήτως του θεωρητικού φακού που ενημερώνει την

κλινική τους εργασία. Σε αυτό το τεύχος, η Ahonen συζητά τον τρόπο με τον οποίο αναπτύσσεται μια θεραπευτική σχέση όταν «οι μουσικοθεραπευτές χρησιμοποιούν εξίσου τη μουσική και τους προσωπικούς τους πόρους ως άτομα» (ελεύθερη μετάφραση) για να επιφέρουν θεραπευτική αλλαγή, μια έννοια που σπάνια συζητιέται στη μουσικοθεραπευτική βιβλιογραφία. Στο κείμενο ο αναγνώστης μπορεί να μάθει για κλινικά θέματα, όπως το να είναι ένας πληγωμένος θεραπευτής [wounded healer] (επειδή οι δικές μας εμπειρίες μας επιτρέπουν να συμπάσχουμε και να κατανοούμε καλύτερα τους άλλους), το να διαχειριζόμαστε την αντιμεταβίβαση [countertransference] και να κατανοούμε τον έμμεσο/δευτερογενή τραυματισμό [vicarious traumatization] (που συμβαίνει μέσω επανειλημμένων εκθέσεων σε τραυματικές αποκαλύψεις πελατών). Αυτά τα προαναφερθέντα κλινικά θέματα οδήγησαν την Ahonen να διεξαγάγει μια διερευνητική μελέτη για το πώς οι Καναδοί μουσικοθεραπευτές ασκούν και αντανακλούν τη χρήση του εαυτού στη θεραπευτική σχέση.

Παρέχοντας επίσης πληροφορίες που σχετίζονται με το πλαίσιο αναφοράς τους, στα κείμενά τους τόσο οι Ramaswamin και Silverman όσο και η Lim αντικατοπτρίζουν την εφαρμογή της θεωρίας για την παροχή ενός πλαισίου υποστήριξης για συγκεκριμένες κλινικές παρεμβάσεις. Με σκοπό την ανάπτυξη μιας νευροεπιστημονικά βασισμένης επιχειρηματολογίας για τη ζωντανή μουσική που προτιμάται από τον ασθενή (patient-preferred live music, PPLM) ως δεκτική παρέμβαση, οι Ramaswami και Σίλσιλμαν πραγματοποίησαν μια βιβλιογραφική ανασκόπηση. Αυτή η ανασκόπηση ωφελεί το επάγγελμά μας αυξάνοντας την κατανόησή μας για τον μηχανισμό μέσω του οποίου η μουσική ακρόαση φέρνει νευροβιολογικές αλλαγές, οι οποίες στη συνέχεια αλλάζουν τις συμπεριφορές και τα συναισθήματά μας. Πτυχές της μουσικής ακρόασης ως νευρολογικής ανταμοιβής, εξοικείωση και προτίμηση (που επιτρέπουν την αίσθηση του ελέγχου και την αποτελεσματική απόσπαση της προσοχής), επιλογή και αυτονομία στην επιλογή της μουσικής, καθώς και η κοινωνική συνιστώσα της μουσικής δημιουργίας γίνονται τα προτεινόμενα θεωρητικά μονοπάτια υποστηρίζοντας τη ζωντανή μουσική ως μια δεκτική παρέμβαση μουσικοθεραπείας. Η Lim από την άλλη πλευρά εφαρμόζει το Βοηθητικό Μοντέλο [Helping Model] του Egan για να εξηγήσει τόσο θεωρητικά όσο και εμπειρικά ερωτήματα σχετικά με την κλινική εργασία με άτομα με διαταραχές που σχετίζονται με κατάχρηση ουσιών. Η συγκεκριμένη θεωρία επεξηγείται μέσω μιας μελέτης περίπτωσης που περιλαμβάνει αξιολόγηση, κλινικούς στόχους και συζήτηση συγκεκριμένων εμπειριών βασισμένων στη μουσική.

Αντανακλώντας τη διεπιστημονική φύση του περιοδικού, οι Κεραμίδα και Βαϊούλη γράφουν σχετικά με τις διαφοροποιημένες διδακτικές προσεγγίσεις στη μουσική εκπαίδευση. Μέσα από μια συνεργασία ερευνητών που συνδυάζουν την εκπαίδευσή τους στην ειδική αγωγή, τη μουσικοθεραπεία και τη μουσική εκπαίδευση, το άρθρο τους παρέχει μια εις βάθος φαινομενολογική ανάλυση των προκλήσεων σχετικά με την αντιμετώπιση των εκπαιδευτικών αναγκών των παιδιών με ειδικές ανάγκες σε τάξεις πρωτοβάθμιας εκπαίδευσης.

Οι συστηματικές μελέτες διαφόρων κλινικών ζητημάτων καθιστούν τα άρθρα σε αυτό το τεύχος πολιτισμικά και επιστημονικά σημαντικά. Οι θεωρητικές γνώσεις σε αυτά τα κείμενα μπορούν να μεταφραστούν σε άμεσες εφαρμογές κλινικών πρακτικών. Οι βιβλιοκριτικές που περιλαμβάνονται σε αυτό το τεύχος αντικατοπτρίζουν επίσης την αύξηση της κατανόησης της έρευνας, χρησιμοποιώντας την έρευνα για την ενημέρωση της κλινικής πρακτικής και συμμετέχοντας σε δια-συνεργατικές δραστηριότητες. Ομοίως, οι αναφορές συνεδρίων

αντιπροσωπεύουν τον διεπιστημονικό διάλογο μεταξύ μουσικολόγων, μουσικών εκπαιδευτικών, εκπαιδευτών ειδικής αγωγής, ψυχαναλυτών και μουσικών ψυχολόγων. Ελπίζω, ως αναπληρώτρια συντάκτρια του *Approaches*, ότι τα τέσσερα άρθρα που περιλαμβάνονται σε αυτό το τεύχος, καθώς και η πληθώρα των βιβλιοκριτικών και των αναφορών από συνέδρια θα ανάψει τη διανοητική περιέργεια των αναγνωστών μας, θα παρέχει σημαντικό υλικό και θα λειτουργήσει ως πηγή έμπνευσης.

Κλείνοντας αυτό το σημείωμα σύνταξης, και εκ μέρους ολόκληρης της ομάδας του Approaches, θα ήθελα να εκφράσω την ευγνωμοσύνη μας προς τα μέλη της Συμβουλευτικής Συντακτικής Επιτροπής που πλησιάζουν στο τέλος της πενταετούς υπηρεσίας τους στην επιτροπή του περιοδικού και οι οποίοι θα αποχωρήσουν μέχρι το τέλος του έτος: Ανθή Αγρότου, Μίτσυ Ακογιούνογλου, Cochavit Elefant, John Habron, Ευθύμιος Παπατζίκης, Μαρία Ποθουλάκη, Hanne Mette Ridder, Shirley Salmon, και Melanie Voigt. Ευχαριστούμε όλους και τον καθένα ξεχωριστά και μεταδίδουμε τη βαθιά εκτίμησή μας για την τεράστια συμβολή τους στο Approaches τα τελευταία χρόνια. Ταυτόχρονα, ένα θερμό καλωσόρισμα στα νέα μέλη της ομάδας που εντάχθηκαν στη Συμβουλευτική Συντακτική Επιτροπή μας τους τελευταίους μήνες: June Boyce-Tillman, Enrico Ceccato, Tali Gottfried, Steven Lyons, Raymond MacDonald, Beth Pickard, Βασιλική Ρεράκη, Lorna Segall, και Anita Swanson.

ΒΙΒΛΙΟΓΡΑΦΙΑ

Stige, B. (2015). The practice turn in music therapy theory. *Music Therapy Perspectives, 33,* 3−11.

ARTICLE

'Self as instrument' – Safe and effective use of self in music psychotherapy: Canadian music therapists' perceptions

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ABSTRACT

This article introduces the results of a pilot survey conducted with accredited Canadian music therapists investigating their perceptions of personal psychotherapy and the concept of *Safe and Effective Use of Self* (SEUS) in the music therapy relationship. An emailed survey questionnaire covered both closed and open-ended questions on SEUS-related topics. The open-ended questions were analysed using the qualitative data analysis software *Nvivo*. Simple percentages were calculated to analyse the results of the closed-ended questions. The results suggest that music therapists engaging in psychotherapy seem to work with similar client populations, use similar theoretical approaches and techniques, and hold very similar training to other music therapists. These music therapists appear to have an excellent sense of SEUS, whether or not they practice psychotherapy. Conversely, their training on both SEUS and verbal counselling skills is often seen as inadequate. It is suggested that music therapists who practice psychotherapy have completed their own psychotherapy and have ongoing music psychotherapy supervision. The results can be utilised as a discussion stimulus for the topic of SEUS in music therapy.

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INTRODUCTION

Generally, music therapists emphasise the importance of the therapeutic relationship between music therapist, client, and their music. Thus, the concept of the music therapeutic relationship refers to verbal, non-verbal, and musical communication and emotional exchange on different levels including intra/interpersonal, and intra/intermusical (Bruscia, 1998a). Just as the music therapy process is much more than musicking together, the music therapist's use of self is more than their capacity to play musical instruments with their client. Certainly, they also use their self as an instrument in the therapeutic relationship. Containing their clients' emotions, music therapists equally use both music and their own person.

In my own experience as a music therapy educator, the term 'use of self' is sometimes confusing for music therapy students. It may be easier for some of them to explain how they use music as a tool of therapy. The term may also be easily misinterpreted as: "*It means that the therapist is personal and friendly with the client…*", "*…that the therapist does not hide his/her emotions from the client…*", "*…that the therapist discloses his/her personal (trauma and recovery) experiences with the client…*" "*…that the therapist is 'real' all the time, even when they've a bad day…*", or "*…that the therapist is happy and cheerful with the client…*"

In the Canadian province of Ontario, since the proclamation of *The College of Registered Psychotherapists of Ontario* (CRPO) on 1st April 2015,[1] only registered psychotherapists can use the title of 'psychotherapist' and practice in the scope of psychotherapy. Therefore, every music therapist working in Ontario must self-declare whether they practice music therapy or some form of music psychotherapy. Young's (2013) definition of music psychotherapy in *The International Dictionary of Music Therapy* has been used as a guideline to aid the Ontario music therapists' professional self-reflection.

> Music psychotherapy [is] the use of music experiences [active or receptive] to facilitate the interpersonal process of therapist and client as well as the therapeutic change process itself (Bruscia 1998b: 2). The use of music for this purpose varies according to the therapist's philosophy or approach (e.g. psychodynamic, humanistic, music-centred, transpersonal) and treatment goals deemed necessary by the therapist and/or client(s). Bruscia (1998a) outlined four levels of engagement used in music psychotherapy contexts, ranging from exclusively musical to exclusively verbal: 1) music as psychotherapy; 2) music-centred psychotherapy; 3) music in psychotherapy; and 4) verbal psychotherapy with music. Some well-known models of music psychotherapy include analytical music therapy (Priestley 1994), GIM (Bonny 2002), vocal psychotherapy (Austin 2009), and group analytical MT (Ahonen-Eerikaïnen 2007). Music psychotherapy can occur in both group and individual treatment contexts. It is generally considered to be an advanced form of MT practice requiring specialized training and/or certification. (Young, 2013, p. 82)

Many Ontario music therapists who self-declared that they practice in the scope of psychotherapy – either music as psychotherapy, music-centred psychotherapy, music in psychotherapy, or verbal psychotherapy with music (Bruscia, 1998a) – have already been approved by the CRPO as registered psychotherapists (RPs). However, many music therapists in Ontario continue practicing music therapy *without* needing to register at the College. This is because not all music therapists identify themselves as psychotherapists. Furthermore, not all music therapy (i.e., neurologic music therapy or community music therapy) fall within the scope of psychotherapy as defined by the Government of Ontario (2007):

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[1] The current CRPO members represent various psychotherapy approaches. The specialisations of individual psychotherapists include diverse practices such as family therapy, pastoral counselling, and arts therapies. See more: www.CRPO.ca

> The practice of psychotherapy is the assessment and treatment of cognitive, emotional or behavioural disturbances by psychotherapeutic means, delivered through a therapeutic relationship based primarily on verbal or non-verbal communication. (The Psychotherapy Act, Section 3, p. 1)

> In the course of engaging in the practice of psychotherapy, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to treat, by means of psychotherapy technique delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning. (The Psychotherapy Act, Section 4, p. 1)

The Canadian Association of Music Therapists (CAMT) and the Music Therapy Association, Ontario (MTAO) have organised several workshops and panel discussions attempting to guide music therapists with their self-declaration process.[2]

According to the competencies articulated by the CRPO and CAMT, a music therapist engaged in the psychotherapeutic practice must meet the entry-level competencies. They must be able to independently practise complex and critical thinking, be able to assess the client's therapeutic needs, determine the appropriate therapeutic aims, and plan and evaluate the ongoing therapeutic process. They must also be able to use the appropriate music therapy/psychotherapy theories, approaches, techniques and interventions based on their clients' needs. Likewise, they need to be able to integrate their theoretical knowledge with their clinical and personal experience, and their personal and clinical experience with their theoretical knowledge. The competencies require that a successful candidate has not only mastered the various clinical (and musical skills) taught in music therapy training and internship, but have also mastered the integration of their clinical skills with their authentic selves. Music therapy trainings must therefore include evaluating students' competencies in academic, professional, clinical, and personal areas. Furthermore, the trainings must teach about Safe and Effective Use of Self (SEUS) in the therapeutic relationship as it is one of the major competencies of psychotherapy practice in Ontario.

The following CRPO definition of the SEUS acknowledges the diverse theoretical background of registered psychotherapists:

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[2] According to Rowlands (2014), the College acknowledges the difficulties and the 'fine lines' in distinctively differentiating between music therapy and music psychotherapy practices:

> Music therapists who do not become members of the College will not be in breach of the Psychotherapy Act, 2007, as long as they do not use the title, Psychotherapist (or any abbreviation of that title); claim to be qualified to practise psychotherapy; and practise the controlled act of psychotherapy, i.e. do not work with clients who have serious mental health disorders, using the techniques of psychotherapy. Music therapists will, however, be able to work with clients who have serious mental health disorders, using the techniques of music therapy (but not psychotherapy). Academics and senior practitioners in the field of music therapy, who are trained in both music therapy and psychotherapy, are best positioned to know where that line is drawn (it will always be a bit fuzzy). (Rowlands, 2014, p. 2)

After the window to be grandparented into the College closed in March of 2017, the music therapists of Ontario have been applying for membership via the route which assesses their psychotherapeutic learning and competencies. Newly graduated music therapists can apply to be accepted as *qualifying members* (RP qualifying) although they are also required to pass an examination testing their competencies to practice psychotherapy.

> One of the defining competencies of psychotherapy practice, Safe and Effective Use of Self refers to the therapist's learned capacity to understand his or her own subjective context and patterns of interaction as they inform his or her participation in the therapeutic relationship with the client. It also speaks to the therapist's self-reflective use of his or her personality, insights, perceptions, and judgments in order to optimize interactions with clients in the therapeutic process. Psychotherapeutic traditions and practices related to the development of a psychotherapist's safe and effective use of self in the therapeutic relationship are diverse. Some applicants will have developed this competency while engaging in their own personal psychotherapy. Others will have taken courses that address use of self; these may include, for example, personal family history and dynamics, anti-oppression and diversity, power dynamics, relational boundaries, experiential practice as client, or interpersonal relationship development. Others may have engaged in a guided and reflective Indigenous practice, such as the four directional ways. For some practitioners, this competency may also address in a particular form of clinical supervision. (CRPO, 2015, p. 1)

The purpose of this article is to introduce the concept of SEUS and explore what it means for music therapists. The literature review will first present the key concepts of the use of self. The survey results will then focus on Canadian music therapists' perceptions of it. Finally, the discussion will further consider the survey results in relation to current literature, highlighting the most important themes that emerged from the data.[3]

USE OF SELF – LITERATURE REVIEW

The idea of SEUS has not yet been published in the music therapy literature, nevertheless there is current material addressing music therapists' self-care (e.g., Trondalen, 2016). There is various literature and research focusing on different aspects, such as the therapeutic musical relationship (e.g., De Backer & Van Kamp, 1999; Kenny, 2016; Pavlicevic, 1990, 1997, 2000; Procter, 2002; Trevarthen & Mallock, 2000), and psychodynamic concepts such as countertransference (e.g., Bruscia, 1998c, 1998d, 1998e, 1998f, 1998g, 1998h, 1998i, 1998j). Nevertheless, the concept of use of self has been extensively researched in the fields of psychotherapy and social work (e.g., Arredondo & Toporek, 2004; Chapman & Oppenheim, 2008; Cheon, 2007; Dewane, 2006; Ganzer, 2007; Heydt & Sherman, 2005; Kondrat, 1999; Lum, 2002; Reinkraut, Motulski & Richie, 2009; Reupert, 2007, 2008, 2009; Shadley, 2000; Ward, 2008).

Generally speaking, use of self refers to the basic foundations of any good and ethical clinical practice, emphasising the therapist's intentional use of their "personality, insights, perceptions, and judgments as part of the therapeutic process" (Punwar & Peloquin, 2000, p. 285). As Satir (2000, p. 25) states: "The person of the therapist is the center point around which successful therapy revolves." Likewise, Reinkraut (2008) underscores the importance of the therapist's moral awareness, pointing

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[3] For the purposes of the next sections, I will use the term 'music therapist' (not 'music psychotherapist'), and 'music therapy' (not 'music psychotherapy'). I believe all music therapists must practice SEUS in their therapeutic relationship.

out that many aspects impact a therapeutic relationship:

> With this in mind I propose that therapist's use of self be understood to mean the intentional use by the therapist of his or her abilities, experience, identity, relational skills, moral awareness, knowledge and wisdom in the service of the therapeutic benefit of the client. (Reinkraut, 2008, p. 15)

Furthermore, as stated by Knight (2012, p. 7): "the therapist's self is best framed as the medium through which she or he engages in clinical practice and as the most basic and primary of the tools that she or he has to bring about client change."

Psychotherapy related research has emphasised the role of the therapist's self in the therapeutic relationship as being a more important factor in the therapeutic outcome than any therapeutic approach or intervention (Lambert & Barley, 2001; Messer & Wampold, 2002). Clarkson (1996) even claims that any therapeutic change occurs within the context of a relationship. Conclusively, Peterson and Nisenholz (1999, pp. 12-14) introduce a list of features any therapist should be aware of when using their self as a tool of therapy. As therapists, we should be insightful and observe both verbal and nonverbal behaviour of the client, and be multiculturally sensitive, breaking out of "our own cultural capsules" (Peterson & Nisenholz, 1999, p. 12). We should be willing to enter into the subjective world of the client and foster an appropriate level of intimate therapeutic relationship, self-disclosure, and confrontation. We should also remain in a continuous process of our own personal growth. While contemplating these various aspects of use of self in therapy, we can argue that all of them are indeed aspects of good clinical practice.

The numerous use of self studies conducted amongst occupational therapists are thought-provoking for the similarities with music therapists' professional identity issues. Noteworthy to music therapy educators are the results in which the occupational therapists felt that they were inadequately trained in therapeutic relationship and use of self (Taylor, Lee, Kielhofner & Ketkar, 2009). These results support an earlier study which pointed out that occupational therapists' concerns over their professional recognition often led them to emphasise their professional knowledge, thus creating authority conflicts within therapeutic relationships. Interestingly, therapists with better personal and professional self-confidence were able to achieve better therapeutic relationships with their clients (Norrby & Bellner, 1995). Furthermore, according to Taylor, Lee, Kielhofner and Ketkar (2009) the more experienced occupational therapists viewed the therapeutic use of self through psychoanalytic concepts (see also Cole & McLean, 2003; Guidetti & Tham, 2002; Peloquin, 2005; Restall, Ripat & Stern, 2003; Sumsion, 2000, 2003). Interestingly for music therapists, a nationwide survey of occupational therapists' attitudes and experiences on use of self concludes that those therapists who valued it and had more training in it

> were more likely to report interpersonal difficulties and feelings of positive regard for clients and were more likely to report concerns about clients. The findings suggest that more attention needs to be paid to the therapeutic relationship and to the therapeutic use of self in education and in research. (Taylor, Lee, Kielhofner & Ketkar, 2009, p. 1)

I will next introduce the key-concepts often mentioned in the use of self literature: being a wounded healer, managing countertransference, and understanding vicarious traumatisation. These concepts will be further deliberated in the discussion section in relation to the themes that emerged from the survey data.

Being a wounded healer

The use of self literature often mentions the concept of being a 'wounded healer' (e.g., Barnett, 2007; Barr, 2006; Bloomgarden & Mennuti, 2009; Dunne, 2000; Guggenbuhl-Craig, 1971; Kirmayer, 2003; Miller & Baldwin, 2000; Nouwen, 1972; Sedgwick, 1994; Sussman, 2007; White, 2000). According to Goethe, our own pain and suffering trains us to understand others' suffering (Groesbeck, 1975). Zorubavel and O'Dougherty Wright's review (2012) points out that the healing power emerges from the healer's ability to use their own woundedness. Furthermore, as stated by Gelso and Hayes (2007, p. 107): "Therapists who deny their own conflicts and vulnerabilities are at risk of projecting onto patients the persona of 'the wounded one' and seeing themselves as 'the one who is healed'." If we cannot access our own experiences of pain, we may have difficulty feeling empathy with the client. Though, essentially,

> being wounded in itself does not produce the potential to heal; rather, healing potential is generated through the process of recovery. Thus, the more healers can understand their own wounds and journey of recovery, the better position they are in to guide others through such a process, while recognizing that each person's journey is unique. (Zorubavel & O'Dougherty Wright, 2012, p. 482)

There is some music therapy literature on the topic. For example, Austin's (2002) wounded healer's perspective, Dunn's (2009) parallel journeys with his client, Salmon's (2014) reflections on music therapy in whole person care at the end of life, Ahonen-Eerikäinen's (2007) reflections of her case study, and Rinker's (1991) article about GIM and healing the wounded healer.

Managing countertransference

The idea of managing is another main concept in the use of self in the therapeutic relationship. The concept was first defined by Freud (1910) as being a result of the client's influence on therapist's unconscious feelings. Currently, there are hundreds of more or less contra dictionary definitions of countertransference (e.g., Carveth, 2011; Fauth, 2006; Gorkin, 1987; Hayes, 2002; LaFarge, 2007; Maroda, 1991; Racker, 1982; Renik, 1993; Rosenberger & Hayes, 2002; Sandler & Rosenblatt, 1976; Searles, 1979; Smith, 2000). Racker's definition (1982) distinguishes between unobjectionable positive countertransference (which refers to caring and feeling affection for the client); complementary countertransference (in which the therapist's feelings complement the client's feelings), and concordant counter-transference (during which the therapist shares the client's feelings). An example of the last of these is when the therapist "thinks they are attending to the client's experience, but in fact they are replicating his or her own past. It is a kind of identification, but a false one drawing from

the therapist's own unresolved issues" (Clarkson, 1996, p. 92). The therapist's blindness to countertransference may also easily engage them "to play the omnipotent analyst" (Friedman, 2002, p. 63). Furthermore, as specified by Winnicott (1975) objective countertransference occurs when "the psychotherapist is reacting objectively to the client's projections, personality, and behavior in the therapeutic relationship" (Clarkson, 1996, pp. 89-90).

There is comprehensive literature available on music therapy and countertransference (e.g., Ahonen, 2014a, 2014b; Ahonen-Eerikäinen, 2003, 2007, 2014, 2016; Austin, 1998; Bruscia, 1998cdefghij; Diaz De Chumaceiro, 1992, 1998; Dillard, 2006; Dvorkin, 1998; Dvorkin & Erlund, 2003; Erkkilä, 1997; Eschen, 2002; Scheiby, 1998, 2005; Hadley, 1998; Isengerg-Grzeda, 1998; Kowski, 2007; Lecourt, 1998; Montello, 1998; Nolan, 1998; Pedersen, 2007; Pellitteri, 1998; Priestley, 1994; Salmon, 2008; Summer, 1998; Turry, 1998; Wilkerson & Dimaio, 2006). Musical countertransference as defined by Templeton (2013) in *The International Dictionary of Music Therapy* (2013) states:

> A relational energy exchange occurring between therapist and client in the context of MT, which is four-fold. The phenomenon encompasses: 1) the mt's unconscious musical reply to the client that is occurring in connection to the mts past relationship dynamics and can become conscious over time; 2) the therapist's unconscious musical reply to the client that occurs in connection to the client's past relationship dynamics; 3) a joining of both 1) and 2) occurring at the same time; and/or 4) an empathic musical response to a client's unconscious state associated with a strong identification to the client (Dillard 2006). (Templeton, 2013, p. 85)

Vegetative resonance (the therapist's somatic symptoms related to therapeutic relationship) are part of countertransference management and use of self in the therapeutic relationship. According to Berger (2001), vegetative resonance can reveal many things, such as the therapist's personal stress, the opening of our own wounds, or fears of not being enough, "unable to contain the horror or relieve the client's pain" (Berger, 2001, p. 193). Furthermore, a therapist may experience physical reactions during therapy sessions or even in anticipation of them. We may feel physical sickness, fear, anxiety, even "an overwhelming desire to get up, leave the session, or at the very least, move […] Physical symptoms may be felt by the therapist before there is any indication of trauma material and can be an indication of some experience of trauma for the client that is undisclosed" (Berger, 2001, p. 193). These reactions can take place when the client describes disturbing material or even when anticipating that they soon will. Notably, "there is often an extraordinary synchronicity present in trauma counselling when the client works with a counsellor with similar personal issues" (Berger, 2001, p. 193). According to Ahonen's (2014a) clinical experiences as a music therapist:

> …my sudden neck, stomach, or back pains during a session may be indicators of counter transference feelings. My somatic resonance may also mirror those feelings the client felt at the time of their original trauma. They can also reflect their fears around coming to the session or being in the session. I have also experienced that it is typical for me to experience somatic resonance when the client himself is dissociated from these feelings. (Ahonen, 2014a, p. 203)

Understanding vicarious traumatisation

Vicarious traumatisation is another concept often associated with use of self. Vicarious trauma can take place anytime when working with traumatised individuals. It has also been called Secondary Traumatic Stress Disorder (STS) (Bride, 2007; Canfield, 2005; Figley, 1995, 2002; Jenkins & Baird, 2002; Kassam-Adams, 1995; Stamm, 1999), or indirect trauma (American Psychiatric Association, 2013; Knight, 2013). As a concept, it is very similar to compassion fatigue, a term often cited by the medical community to explain stress and fatigue in nurses when they compassionately try to do everything to lessen their patients' pain (Baranovsky, 2002; Conrad & Kellar-Gentry, 2002; Guenther, 2003; Killian, 2008; Mathieu, 2012; Racokzy, 2009; Rothchild, 2006). Fundamentally, for any therapist who is compassionate and empathetic, it is impossible to remain emotionally detached and non-responsive. Because therapists repeatedly listen to traumatic disclosures while having to control their reactions, they may become vicariously traumatised (Izzo & Carpel Miller, 2011). As stated by Pearlman (2014):

> All of the trauma work that we do, hour after hour, day after day, week after week… contributes to inner changes in the self of the therapist. It's an inevitable part of the work… because we're entering into a very dark world, and if we're open emotionally, in the way we need to be to be effective helpers, we're going to be impacted. (Pearlman, 2014, p. 1)

Dale (1999, p. 41), in his study of health care professionals working with adults abused as children, found that some degree of emotional strain was reported by most of these professionals, and that they felt disgust, powerlessness, identification with the victim, and anger with the perpetrator. Sometimes the vicarious traumatisation strikes the therapist in response to trauma stories within a group of peers or a therapy group. If the therapist does not address their symptoms, they may begin to act out with clients, become controlling, easily angered, or just simply stop listening (Klein & Schermer, 2000, p. 8).

Interestingly, "indirect exposure to aversive details of the trauma, usually in the course of professional duties" is referred to in the current DSM-V, criterion A (American Psychiatric Association, 2013), as being one of the stressors for the post-traumatic stress disorder (PTSD) diagnosis. The symptoms may include fatigue, helplessness, tearfulness, irritability, vulnerability to over stimulation, dissociative symptoms, nightmares, disturbing images, flashbacks of stories heard from trauma survivors, numbness, fear of future, self-blame, dampened meaning of life etc. Symptoms also include becoming cynical, fearful, or overprotective. As a result of vicarious traumatisation, we may begin to set up rigid boundaries in our personal relationships, but simultaneously experience lack of boundaries in our clinical work (Ahonen, 2014a, 2016). Furthermore, vicarious traumatisation may damage therapists' emotional and spiritual well-being, and destroy their self-image, world view, and belief system.[4] (If not properly addressed, vicarious traumatisation, compassion fatigue, and a long lasting

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[4] See also: Brady, Guy and Richardson (2001), Eidelson D'Alessio and Eidelson (2003), McKann and Pearlman (1990a, 1990b), Palm, Smith and Follette (2002), Pearlman and Maclan (1995), Pearlman and Saakvitne (1995a, 1995b), Saakvitne and Pearlman (1996), Sabin-Farrel and Turbin (2003), Schauben and Frazier (1995), and Van Dernoot Lipsky and Burke (2009).

emotional exhaustion can lead to burnout (Edelwich & Brodsky, 1980; Farber, 1983; Maslach, 2003; Wessells, Selder, Kutschr, Cherico & Clark, 1989).

The following section introduces the survey results that focus on Canadian music therapists' perceptions of SEUS and psychotherapy. Thereafter follows a discussion highlighting the most important themes that emerge from the data in relation to current literature.

CANADIAN MUSIC THERAPISTS' PERCEPTIONS ON SEUS AND PSYCHOTHERAPY – PILOT SURVEY

The aim of this exploratory pilot survey was to gain insight into Canadian music therapists' reflections on personal psychotherapy and the concept of SEUS in the music therapy relationship, and to stimulate discussion on the topic. The study was approved by the Ethics Review Board of Wilfrid Laurier University.

Method

An emailed survey questionnaire (in English and French) covered 42 closed and 11 open-ended questions on SEUS-related topics. The research participants were CAMT accredited music therapists (MTAs) who were identified by the CAMT accreditation list. To invite MTAs to complete the survey, each was emailed the introductory letter, informed consent, and a survey link. The survey was emailed to all CAMT registered MTAs ($n = 609$). 69 of these volunteered to participate in the study. Some participants also emailed the researcher their additional thoughts after they had completed the survey. The participants' average age was 39, and they were mostly females (86%). The open-ended questions were analysed using the qualitative data analysis software *Nvivo* and by creating descriptive categories. Descriptive statistics were used to analyse the results of the closed-ended questions.[5]

Results

The results introduce the Canadian music therapists' engagement in the scope of psychotherapy and their reflections on SEUS and personal psychotherapy. The results also include suggestions for music therapy trainings to enhance SEUS competency. For readability, I will use acronyms for music therapy [MT], psychotherapy [PT], personal psychotherapy [PPT], music therapists [MTs], and music therapists engaged in the psychotherapy practice [MTPTs].

Music therapists' engagement in the scope of psychotherapy – training, theoretical approaches, and techniques

Almost half of the participating MTs ($n = 31$) indicated that they were engaged in the field of psychotherapy (PT) and therefore practiced music therapy (MT) in the scope of psychotherapy (PT).

Half of the participating MTs had bachelor degrees, whereas the other half also held a graduate level degree. However, most of the MTPTs (74%) had a master's degree. Interestingly, all MTs, whether or not they practised PT, seemed to work with a similar type of client population, children and adults, with diverse diagnosis. Additionally, MTPTs also worked with people with psychological trauma, PTSD, anxiety, depression, or other psychiatric disorders. 74% of MTPTs were engaged in full-time PT. Most of them practised individual therapy with over half practising group therapy as well.

Most of the MTs (95%), whether they practised PT or not, had some level of psychotherapeutic continuing education. For example, 76% had completed trauma therapy or crisis intervention trainings, and 34% had taken some level of GIM training. Likewise, out of the MTPTs, 39% hold some level of GIM training, yet only 10% were Fellows. Interestingly, 32% of MTPTs held some level of Nordoff-Robbins training. Similarly, 29% of them had taken a basic course in Neurologic MT. It appears that the training did not differ whether or not the MTs practised PT or not.

Furthermore, the theoretical orientations of MTPTs did not differ from other MTs either. Person-centred and humanistic existentialistic approaches seemed to be most common. The strongest influences for all MTs, whether or not they practised PT, were music-centred aesthetic MT (e.g., Lee, 2003), Nordoff-Robbins, GIM, and analytical MT.

Music therapists' reflections on learning SEUS

In Ontario, a successful CRPO applicant must have completed a minimum of 30 hours of education and training related to SEUS in the psychotherapeutic relationship. SEUS-related entry-to-practice competencies required for registration with the CRPO include:

> 4.3 Ensure safe and effective use of self in the therapeutic relationship.
> 4.3.1 Demonstrate awareness of the impact of the therapist's subjective context.
> 4.3.2 Recognize the impact of power dynamics within the therapeutic relationship.
> 4.3.3 Protect client from imposition of the therapist's personal issues.
> 4.3.4 Employ effective and congruent verbal and non-verbal communication.
> 4.3.5 Use self-disclosure appropriately. (CRPO, 2015, p. 1)

According to the survey results, the most important source for learning SEUS was clearly the MTs' personal psychotherapy (PPT) (65%). Furthermore, 35% mentioned experiential courses during MT training, and workshops organised by the CAMT (29%). Most of the MTs also mentioned ongoing supervision. Other sources cited were internship in a psychotherapeutic setting, self-studies (reading literature), and GIM training. However, some comments clearly indicated that there had not been enough training on SEUS:

> This was not addressed in my training. There has not been to date a lot offered via SEUS.

> My guidance has come from mentors, reading, ethics training and self development.

According to the CRPO (2015, p. 1), one of the entry-level competencies required for registration is to be able to employ effective and congruent verbal and non-verbal communication in therapeutic relationships. Amongst survey respondents, song-writing, clinical improvisation, and GIM were the most commonly cited therapeutic techniques. Other techniques mentioned included receptive techniques such as music for relaxation and mindfulness, guided visualisation, or lyric analysis. Moreover, psychotherapeutic voice work and toning were utilised as well as creative arts therapy techniques such as drawing/writing/moving to music. Interestingly, almost half of the MTPTs also incorporated adapted music education and neurologic MT techniques. Many MTPTs also included community choir or bands as their therapeutic technique (23%). Although speculative, this could be rationalised as MTPTs practicing partly PT and partly other types of MT in order to meet their clients' therapeutic needs, or possibly as an additional source of income.

Interestingly, only 77% of the MTPTs incorporated verbal psychotherapeutic techniques (VPT), such as clarification, probing, active listening, and reflective questions with their clients. Furthermore, some indicated they used them only

> at the most basic level which I learned during internship and in master's training.

The main reasons cited for not utilising VPT were either not feeling qualified or because of the particular therapeutic needs of a certain client population:

> The [verbal] methods are not appropriate to the specific populations I'm currently working with.

Only 65% of the MTPTs had learned VPT during their graduate level MT training. Over half of this group had learned VPT during verbal psychotherapeutic training, and slightly less during GIM training. A mere 32% indicated they had learned VPT during their undergraduate MT training. A small number indicated they had not learned VPT at all.

Music therapists' reflections on personal psychotherapy (PPT)

81% of the MTPTs specified that they had been engaged in PPT before, during or after their MT training. The most often cited reason was:

> I needed my personal therapy in order to use my self as a tool safely and effectively.

Techniques such as GIM, clinical improvisation, group analytic music therapy interventions, and various creative arts techniques which many music therapists experienced during their MT training experientials, were all considered beneficial. Analytic listening, especially working with transference, and mindfulness were also mentioned. Not surprisingly, many MTs described that they used music for their own therapy. However, only 45% of the MTPTs engaged in their PPT process had experienced at least a section of it in music psychotherapy, mainly in GIM. Other music psychotherapy experiences

included music and creative arts therapy, group analytic music therapy, and Nordoff-Robbins approaches. Those who had participated in GIM training found it extremely valuable, claiming:

> To date, GIM has been one of the most powerful and healing experiences of my life. The insights gained from my GIM sessions continue to stay with me. I most likely would not have become aware of my unconscious thoughts and feelings without experiencing GIM.

> It [GIM] was a very powerful therapy for me. I appreciated the way the music would allow me to bring up issues from my unconscious, so they could be looked at and processed verbally or in creative mediums afterwards.

The results suggested the main reasons why MTPTs had not been engaged in music psychotherapy were the small size of their communities, and concerns over potential dual relationships:

> I haven't found a music therapist who isn't a friend who practices with a worldview I would find useful in my own therapy.

> Small profession – wanting to remain colleagues in Canada rather than enter into a client/therapist relationship with colleagues and people whose work I respect.

> Small community, I prefer seeing someone I'm not acquainted with/don't know.

> If I wanted to have music psychotherapy I would not be able to find a practitioner who was sufficiently qualified and not in a dual relationship with me (our professional community is simply too small).

Benefits of personal psychotherapy

Those MTPTs who had PPT experience described the many benefits they gained from it. The list includes gaining understanding of clients' experience, learning about SEUS, personal growth, working through past trauma, and self-care.

Understanding client experience

The most often cited benefit of PPT was that it allowed music therapists to *"have the experience of being the client in therapy."* It allowed *"better understanding of client perspective as a participant in music…"* PPT also helped the MTs to gain understanding of their clients' experience in relation to various interventions. For example:

> Learning the effectiveness of musical and verbal interventions.

> I believe that personal therapy gives you a good perspective about what we ask of our clients but also an awareness to understand that the same technique is not going to work for everyone…

Learning about SEUS

Many music therapists mentioned that their PPT taught them how to utilise SEUS, for example,

> better ability to engage in the safe and effective use of self.

> further understanding of the use of music as a psychotherapeutic tool.

> To work in any depth, personal therapy is essential. Unfortunately, even when music psychotherapy is available, most music therapists do not take advantage of it.

PPT experience also seemed to highlight the impact of the therapist's authenticity and transparency, guarding safe boundaries, and managing countertransference.

> …it taught me how important sense of safety and boundaries are in therapy.

> I learned how crucial it is that the therapist is authentic, and not fake. I also learned the impact of therapist's transparency (when it is not therapeutic).

> … learned how essential it is for the therapist to manage counter transference and not to treat the client based on their own assumptions.

> … I learned about somatic reactions, both mine and the therapists…

Personal growth and working through past trauma

The benefits of PPT included aspects of personal growth such as increased self-esteem, increased self-awareness, greater clarity in decisions, and strengthened personal resources. Some mentioned processing trauma and grief, decreased anxiety, transforming negative patterns, and integrating life experiences.

> I cannot work with traumatized clients if I have not worked through my own personal trauma.

> Music making is connected to the body. It helps make connections or can be grounding when you're dissociating or unable to feel.

> Being able to explore and process personal issues.

> …deep processing of emotions that went beyond verbal awareness.

> …using the music to help tap the subconscious and get out of my head and my
> stories.

Self-care

Self-Care was often mentioned as a benefit of PPT, because:

> …it is crucial [for an MT] to take care of their own therapeutic needs also…

> There is something very unique about being a care provider and having someone
> else provide that care to you.

Furthermore, a small number of MTPTs also disclosed that they had experienced vicarious traumatisation or burnout themselves.

> I did not truly understand its [SEUS's] importance until I burnt out and was very
> close to being an ineffective therapist, which when working with mental health
> patients, it is potentially quite dangerous.

> …there must be an ongoing clinical supervision during the training and after the
> training…

Suggestions for music therapy training programs to enhance SEUS competency

Participating MTs applauded the regular clinical supervision during their clinical practicum and internship as a main forum for learning SEUS. They also complimented the teaching of musical resources as clinical interventions. Nevertheless, they also provided many valuable suggestions and ideas that could be incorporated into the MT curriculum to enhance the entry-level SEUS competency of graduates as defined by the CRPO (2015). The prevalent tone of the suggestions were that *"a healthy/safe/effective use of self should be a part of every training program, even undergraduate"*, and *"There needs to be a change in the way we teach the importance of the healthy and effective use of self in music therapy."* Music therapists reflecting on their own training suggested the following SEUS components be added to or enhanced in music therapy training.

1. Teach safe and effective use of self (SEUS) in the therapeutic relationship

MT trainings should incorporate more opportunities to explore and learn the importance of SEUS and its concepts in therapeutic relationship, such as countertransference, power dynamics, therapists' self-disclosures, and non-verbal communication. The concepts of vicarious traumatisation, compassion fatigue and burnout should also be explored during the training and at regular intervals during the clinical supervision. The training should assist students to understand the differences between their own therapeutic process and that of their clients, and, when working with diverse client populations, to protect clients from imposition of the therapist's personal issues.

> For a therapist who works with those who are non-verbal and have impaired functioning with behaviour issues, 'healthy and effective use of self' needs and approaches are different. There are similarities - but there are needs/approaches that are unique to working with this group.

> I feel strongly that music therapists should be well-trained as therapists - verbal and music, including significant psychotherapeutic training and personal therapy. I think we can only go as deeply with others as we have gone in ourselves, and that knowing how to process emotion verbally is essential for music therapists.

> Help students to understand that they are still at the beginning stages of learning when they complete their training. Many interns I have encountered are often over-confident and unable to truly see their areas of growth during the beginning months of the internship.

> We need to have more personal stories from those working in the field about the difficulty but importance of self-care as it pertains to the effective use of self. … As well as truly speaking to each student individually and having them understand the potential damaging effects it could have.

1.1. Involve extensive music-making and improvisation beyond basic primary development of voice, guitar, and piano to enhance students' musical transparency and authenticity. Students should *"explore the self in relation to the music,"* and *"include more hours of self clinical improvisations in peer groups as well as one on one basis."*

1.2. Teach verbal psychotherapy techniques to meet the CRPO competency requirements. It was suggested that:

> An introductory counselling course would be really helpful for music therapists in training. Learning and practicing basic active listening and interviewing skills (validation, open-ended questions, paraphrasing, etc.) is extremely important for music therapists, even when they aren't doing psychotherapy, and I don't feel that I learned those techniques adequately in my undergraduate degree.

> …there needs to be more discussion on how to use verbal psychotherapy before finishing the undergrad degree. Everything I learned in this area was from my internship supervisor.

2. Require personal psychotherapy for music therapy students

It was expressed that personal psychotherapy should be encouraged prior to entering the field and it should become a mandatory part of the education.

2.1. Encourage personal psychotherapy prior to entering the field. There should be better screening of candidates ensuring they have engaged in PPT, ideally music psychotherapy.

> Music related psychotherapy counselling session as pre-requisite for completing the music therapy training.

> I think it's important to stress that potential MT students have had their own personal therapy, in whatever modality is best suited to them.

> I had already had years of therapy before becoming an MT student, and I still felt that I had a lot more personal work to do before I could be an effective therapist (interpersonal work, relational work).

2.2. Require mandatory personal psychotherapy (verbal psychotherapy or music psychotherapy) during the MT training.

> Outlining the benefits of engaging in personal psychotherapy and inviting students to do so - role play, including verbal intervention as well as music psychotherapy technique.

> Make attending personal psychotherapy a requirement of the program.

> All students should be required to take the 'client' role in a period of personal therapy.

> When I was in school it was recommended but not mandatory. I hope that as the profession continues to grow that it will be a standard in the education process for upcoming MT's.

> In my opinion, on-going 'self' or 'therapeutic' work is critical in order to be a healthy, effective therapist. It's almost as important, if not more, than continuing education. Setting this standard, example and requirement during MT training would be beneficial for individuals as well as the profession.

REFLECTIONS AND DISCUSSION

As the response rate of the survey was only 12%, the results cannot give a comprehensive picture of Canadian music therapists' views on SEUS. Furthermore, it is likely that responses were biased by the greater likelihood of inclusion of therapists who had a higher level of interest in SEUS. Despite its limitations, the results serve to stimulate a wider conversation about SEUS and related training needs amongst music therapists and music therapy educators.

According to the survey results, music therapists engaging in psychotherapy in Ontario seem to work with similar client populations as other music therapists do. They appear to use similar theoretical approaches and techniques, and hold very similar training.

The findings of the survey suggest that music therapists have an excellent sense of SEUS, whether or not they practice psychotherapy. They clearly value the SEUS and the benefits of their own personal therapy. However, at the same time, some portrayed their training on SEUS, including verbal

counselling skills, to be inadequate. This is important information for the music therapy educators to consider as the required CRPO SEUS-related entry-to-practice competencies include the therapist's capacity to employ effective and congruent verbal and non-verbal communication (CRPO, 2015). Furthermore, music therapy trainings are suggested both to teach verbal psychotherapy techniques to meet the CRPO competency requirements, and to involve extensive music-making and improvisation to enhance students' musical transparency and authenticity. The role of local music therapy associations could be to ensure proper continuing education, i.e., pre-conference workshops and intensives. It was also suggested that personal psychotherapy should be encouraged prior to entering the field, and should become a mandatory part of the education.

Those music therapists with some personal psychotherapy experience described the many benefits they garnered from it. The list included gaining understanding of clients' experience, encompassing the importance of authenticity, boundaries, and countertransference management; learning about SEUS; personal growth; working through past trauma, and self-care. The following discussion will further ponder these themes in relation to current knowledge in the field.

According to the survey results, one of the benefits of personal psychotherapy amongst music therapists was to gain understanding of clients' experiences during the therapy process. This included the importance of a therapist's authenticity and transparency, which directly references the CRPO SEUS-related entry-to-practice competency requirements for registration: "Use of self-disclosure appropriately" (CRPO, 2015, p. 1).

The impact of transparency and here-and-now disclosures have been widely researched for decades in psychotherapy-related literature (e.g., Barrett & Berman, 2001; Bloomgarden & Rabinor, 2000; Burkard, Knox, Green, Perez & Hess, 2006; Constantine & Kwan, 2003; Fisher, 2004; Ganzer & Ornstein, 2004; Goldstein, 1994; Hendrick, 1988, 1990; Henretty & Levitt, 2009; Knox, Hess, Petersen & Hill, 1997; Knox & Hill, 2003; Peca-Baker & Friedlander, 1989; Raines, 1996; Sweezy, 2005; Tantillo, 2004; Zur, 2009; Watkins, 1990). Remarkably, there-and-then disclosures are considered less therapeutic even though many therapists may equate them with use of self (Jeffrey & Austin, 2007; Kelly & Rodriguez, 2007). Any disclosures that communicate similarities between therapist and client are not as helpful as generally thought. Indeed, self-disclosures about our personal life, beliefs, values, world views etc. may even disturb the therapeutic relationship (Knight, 2013).

Rogers (1957), the pioneer of client-centred approaches, proclaims that the choices we make concerning the use of self in a therapeutic relationship should be based on two questions: What is authentic for ourselves? And what will meet the client's therapeutic needs? According to psychotherapy research, there are two types of self-disclosure: here-and-now disclosures and there-and-then disclosures (e.g., Baldwin, 2000; Edwards & Bess, 1998; Hanson, 2005; Kelly & Rodriguez, 2007; Peterson, 2002; Prilleltensky, 1997; Sugarman & Martin, 1995).

As music therapists, if our genuine here-and-now self-disclosure conveys our authentic reactions to the client's experiences or our thoughts about the client, the disclosure can be very therapeutic and enhance trust and the therapeutic alliance. However, there-and-then self-disclosures, information about the therapist, can also be helpful in developing the therapeutic relationship if they are controlled. For example, disclosures that expose our professional background, theoretical orientation, or cultural background may be helpful.

One of the most important aspects any music therapist brings into a music therapy practice is their musical authenticity, musical self (e.g., Aldridge, 1999; Bruscia, 2012; Chong, 2007; Hadley, 2006; Lee, 2012, 2016; Pavlicevic, 2000; Yehuda, 2002), and musical transparency. We listen to our own music and musical self while we improvise with a client in a musical, and therapeutic relationship. Moreover, we listen to our feelings in our own music in relationship with client's music (Arnason, 2002; Lee, 2000, 2003).

Most likely our musical authenticity during improvisations has more impact on our clients than our musical skills or theoretical orientation. According to Yehuda (2002, p. 1504), "Music is considered to be authentic when it sounds authentic or when you are feeling that it's real, when it has credibility, and it is perceived as unique." Moreover, the level of intimacy during improvisation can be much higher than in verbal dialogue and often demands even more awareness for the therapist.

According to the survey results, therapists' self-disclosures and their impact is not covered sufficiently during the music therapy trainings. As a music therapist, prior to disclosing information of past experiences it is prudent to ask oneself whether one is disclosing these items for the client or for oneself. What would be the therapeutic goal of these disclosures? How would this content serve a client's therapeutic process? It is imperative for music therapy trainings to stress the importance of therapists not imposing or unconsciously projecting their own values, worldviews, or beliefs upon clients.

As suggested by the participating music therapists, to gain an understanding of countertransference management, including the therapist's somatic reactions, it is crucial that music therapists who practice psychotherapy have completed their own psychotherapy and have ongoing music psychotherapy supervision. This directly reflects with the following CRPO SEUS-related entry-to-practice competencies: "Demonstrate awareness of the impact of the therapist's subjective context, and recognize the impact of power dynamics within the therapeutic relationship" (CRPO, 2015, p. 1).

Many psychotherapists agree that countertransference is "the key in helping the therapist to understand the transference" (Grotstein, 2009, p. 38). However, it can be both "a useful tool and a pitfall of treatment of trauma and traumatic loss" (Klein & Schermer, 2000, p. 7). Despite the fact that the countertransference concept entails the concepts of psychoanalytically and psychodynamically informed psychotherapies, regardless of our theoretical approach as music therapists it is critical that we are willing to do our best to separate our own personal material from our reactions to our client's trauma story and issues. In order to practise safely we must be aware of the subjective countertransference (what is taking place within our psyche), and the objective or realistic countertransference (how it is related to what is happening in therapy session right now) (Klein & Schermer, 2000, p. 28). Even if we do not agree with the psychoanalytic concept of countertransference, recognising its impact remains one of the main areas of SEUS.

Another topic music therapists gained greater understanding of during their personal psychotherapy was the importance of guarding safe boundaries in the therapeutic relationship. There is some literature about boundaries in music therapy. One example, Bunt and Hoskyns (2002), introduced physical and time-based, professional, ethical, and developmental aspects of boundaries. Compton Dickinson and Benn (2012) describe professional and therapeutic boundaries in music therapy in forensic settings. There is also a vivid discourse about boundaries in community music

therapy (Ansdell, 2002; Ansdell & Pavlicevic, 2004). Furthermore, both the CRPO and CAMT *Code of Ethics and Standards of Practice* highlight boundary issues, aiming to protect the public, monitor the welfare of clients, and ensure the therapist does not do harm.

As stated by Bruscia (1998h), if a therapist has boundary issues, two anti-therapeutic polarised reactions occur. If we over identify with the client, we stand to lose our emotional boundaries and may not differentiate between our own and our client's feelings and experiences. "When music-making is involved, the music of the therapist and client become so fused, structurally and emotionally, that the parts are indistinguishable and resistant to change" (Bruscia, 1998h pp. 81-82). The opposite anti-therapeutic reaction occurs when the therapist is trying to distance themselves from the client, building emotional barricades and protection in order to avoid emotions and a genuine therapeutic relationship. They may feel unconnected for long periods, or unable to empathise. "When music-making is involved, the parts of the client and therapist are so completely differentiated that the music sounds conflictual or incoherent and stays that way for long periods" (Bruscia, 1998h, p. 82). I believe the therapist's position to emotionally receive clients' material is sometimes difficult as the professional defence mechanisms simply may not be available. Furthermore, as a therapist, if I over-emphasise the professional distance, my client may not experience empathy and will not be truly helped.

As reported in the survey results, a number of music therapists had experienced burnout themselves. Some suggested a lack of boundaries as the main trigger. Thus, the importance of developing understanding of therapeutic boundaries during music therapy training, internship, and supervision cannot be overstated. Similarly, it would also be critical to teach music therapy students to learn to recognise the symptoms and warning signs associated with burnout, such as bringing clients' problems home, accusatory and martyr-like feelings, or detachment during which clients have become the 'caseload'.

Many participating music therapists mentioned the importance of self-care and finding ways to alleviate therapists' stress, both personal and work-related. Vicarious traumatisation was mentioned several times as something that music therapists wished they had learned about during their training. According to Ahonen:

> The sound of pain and hope does not leave any music therapist untouched and untransformed. Sometimes it follows us into our homes, into our relationships, even our dreams. It may even change our worldview, our values, and our attitudes. It may impact us to become vicariously traumatized. (Ahonen, 2014a, p. 201)

Several elements contribute to vicarious traumatisation, such as lack of psychological breaks and opportunities to ventilate feelings during the clinical work, or an unbalanced caseload. However, the most prevalent reason is inadequate training in the trauma and grief therapy processes, and a lack of supervision (Izzo & Carpen Miller, 2011). As suggested by the survey results, highlighting the importance of self-care and learning concepts such as vicarious traumatisation should be essential at undergraduate level training. Self-care is a crucial part of safe use of self. The survey results suggested that personal therapy should be mandatory in music therapy trainings, not only as an issue of ethical

concern, but also because it includes the self-care of the therapist. As therapists, practising safely means that we do not harm the client or ourselves. In order to keep the clients safe, the therapist must also remain safe. Cattanach puts it beautifully:

> The therapist must seek help and supervision, … know when to stop and rest. Have time away from the work, other things to do and enjoy. Find a safe place to stay contained; a place to travel towards in the imagination and in reality. (Cattanach, 1992, p. 196)

The survey participants' suggestion of making personal psychotherapy mandatory for music therapy students directly reflects the following CRPO SEUS-related entry-to-practice competency required for registration: "Protect client from imposition of the therapist's personal issues" (CRPO, 2015, p. 1). It also reflects the concept of being a wounded healer. Just as many psychotherapists are wounded healers (e.g., Miller, 1981), the survey results suggest many music therapists are also. It is important to reflect what this could mean in our clinical practice. How has our own pain trained us to understand others? How do we use our own woundedness in the service of healing, through empathy and countertransference? What do we have to be aware of during this very sensitive process? Do we agree with the following statement from Bruscia (1998c)?

> …not only that the music therapist should heal himself but also that they should take their own medicine. Any music therapist who has not, cannot, or will not experience music therapy as a client needs to change professions […] every music psychotherapist should do intense personal work over an extended period in whatever form of music psychotherapy he will be practicing. (Bruscia, 1998c, p. 116)

Interestingly, many use of self researchers emphasise that it is crucial to distinguish between the wounded healer and the impaired professional, whose personal trauma experiences harmfully impact their clinical work (e.g., Costin & Johnson, 2002; Gilroy, Carroll & Murra, 2001; Jackson, 2001; Rippere & Williams, 1985; Schoener, 2005; Sherman, 1996; Smith & Moss, 2009). It is generally recommended that therapists must be able to acknowledge their own traumatisation, seek help, and first heal themselves. Our own healing process must at least have started before we can begin to treat clients (e.g., Farber, Manevich, Metzger & Saypol, 2003; Norcross & Connor, 2005; Orlinsky, Schofield, Schroder & Kazantzis, 2011; Sawyer, 2011). Nonetheless, there has been little research into how a therapist's own recovery processes impact their clinical work, or how they determine they are adequately healed in order to be able to practise safely. Thus, "the ambiguity regarding the degree to which the therapists' own wounds have healed presents a dilemma for both the wounded healer and other professionals" (Zorubavel & O'Dougherty Wright, 2012, p. 482).

At the CRPO, it is the registered psychotherapist's gatekeeping responsibility to address and report any deficiencies in colleagues. Inherently, would this hinder open consultations with the colleagues, and authentic disclosures in clinical supervision "about how a colleague's or supervisee's wounds positively influence or interfere with their work?" (Zorubavel & O'Dougherty Wright, 2012, p. 482). Furthermore, according to Zorubavel and O'Dougherty Wright (2012, p. 482) there has been

silence on this topic: "The wounded healers' concerns often pertain to potential stigma if the nature of the wound is disclosed and judgment by colleagues regarding their competence to practice. These concerns can result in secrecy, self-stigma, and shame" (see also Knox, Burkard, Edwards, Smith & Schlosser, 2008; Yourman, 2003).

To summarise, 'safe' use of self in music therapy refers to the twofold idea of (1) not harming the client, and (2) not harming ourselves (self-care of the therapist). Generally, this means that a music therapist does not use their client to meet their own therapeutic (or other) needs, but rather protects them from their own personal issues by being aware of the impact of any power dynamics or their subjective context on the therapy process. Safe use of self also includes the therapist's self-care, i.e., being able to recognise vicarious trauma, compassion fatigue, or burnout signals, and having enough clinical supervision, personal therapy, and a balanced life rhythm.

'Effective' use of self refers to the skilful use of appropriate therapeutic interventions (musical and verbal) in order to meet the needs of a diverse clientele. It also refers to using our self as a tool and container to meet different individuals' needs. Effective use of self also means that the music therapist is able to reflect critically on any personal life philosophies and worldviews that could possibly impact on their clinical work. Without biases or conflicting interests, the therapist, again, by using their self, must be able to assess the client's individual therapeutic needs, plan and conduct a therapeutic treatment, evaluate the process, change the treatment plan if needed, apply appropriate theories and approaches, and at the same time integrate understandings of their own self into the therapeutic relationship. The CRPO SEUS-related entry-to-practice competencies include the following competencies: "to ensure safe and effective use of self in the therapeutic relationship and employ effective and congruent verbal and non-verbal communication" (CRPO, 2015, p. 1). Effective music therapy training should therefore include teaching both musical interventions and verbal interventions. In order to meet the needs of diverse clients, musical interventions should include multicultural musical resources.

Although not the focus of this article, along with the concept of use of self there also needs to be a critical discussion centred on the concept of safe and effective use of music (SEUM). This involves acknowledging the contraindications of using particular music with particular clientele. Similar to not utilising SEUS, not utilising SEUM may present real physical, neurological, and psychological dangers that could possibly harm the client.

Finally, a good music therapy training should encourage students' personal, musical, and professional growth, and equip them for self-care and work with diverse, multicultural client populations with a variety of therapeutic needs. This includes facilitating students' empathy, self-awareness and self-reflection skills by teaching SEUS, and encouraging them to develop their own musical self so that they might use music as their own, unique self-care as well.

In closing, according to Aponte and Winter (2000, p. 85), "At bottom, the single instrument each training model actually possesses is the 'person' of the therapist in a relationship with a client." The concept of use of self offers a framework for music therapists to understand more fully their responses with clients. In this framework we could argue that because we use our own person as a tool of therapy, many of the things we do as music therapists, including our musical interventions, could be considered as use of self. The music therapist's self-awareness, self-acceptance, self-regulation, and personal growth are crucial foundations for the use of self in the therapeutic process. In order to practise safely

and effectively, a recurrent critical reflection is indispensable.

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Ελληνική περίληψη | Greek abstract

'Ο εαυτός ως εργαλείο' − Ασφαλής και αποτελεσματική χρήση του εαυτού στη μουσική ψυχοθεραπεία: Αντιλήψεις Καναδών μουσικοθεραπευτών

Heidi Ahonen

ΠΕΡΙΛΗΨΗ

Αυτό το άρθρο παρουσιάζει τα αποτελέσματα μιας πιλοτικής έρευνας που διεξήχθη με διαπιστευμένους Καναδούς μουσικοθεραπευτές διερευνώντας τις αντιλήψεις τους σχετικά με την προσωπική ψυχοθεραπεία και την έννοια της *Ασφαλούς και Αποτελεσματικής Χρήσης του Εαυτού* (ΑΑΧΕ) [Safe and Effective Use of Self, SEUS] στη μουσικοθεραπευτική σχέση. Ένα ερωτηματολόγιο μέσω ηλεκτρονικού ταχυδρομείου κάλυψε τόσο κλειστού όσο και ανοικτού τύπου ερωτήσεις για θέματα που σχετίζονται με την ΑΑΧΕ. Οι ανοικτές ερωτήσεις αναλύθηκαν με τη χρήση του λογισμικού ανάλυσης ποιοτικών δεδομένων *Nvivo*. Απλά ποσοστά υπολογίστηκαν για την ανάλυση των αποτελεσμάτων των ερωτήσεων κλειστού τύπου. Τα αποτελέσματα δείχνουν ότι οι μουσικοθεραπευτές που εμπλέκονται στην ψυχοθεραπεία φαίνεται να εργάζονται με παρόμοιους πληθυσμούς πελατών, να χρησιμοποιούν παρόμοιες θεωρητικές προσεγγίσεις και τεχνικές, και να κατέχουν παρόμοια εκπαίδευση με άλλους μουσικοθεραπευτές. Αυτοί οι μουσικοθεραπευτές φαίνεται να έχουν μια εξαιρετική αίσθηση της ΑΑΧΕ είτε ασκούν ψυχοθεραπεία είτε όχι. Αντιστρόφως, η κατάρτισή τους τόσο στην ΑΑΧΕ όσο και στις προφορικές συμβουλευτικές δεξιότητες θεωρείται συχνά ανεπαρκής. Οι μουσικοθεραπευτές που ασκούν ψυχοθεραπεία προτείνεται να έχουν ολοκληρώσει προσωπική ψυχοθεραπεία και να έχουν συνεχή εποπτεία μουσικής ψυχοθεραπείας. Τα αποτελέσματα μπορούν να δώσουν ώθηση για περαιτέρω συζήτηση σχετικά με το θέμα της ΑΑΧΕ στη μουσικοθεραπεία.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

Ασφαλής και Αποτελεσματική Χρήση του Εαυτού (ΑΑΧΕ) [Safe and Effective Use of Self, SEUS], επάγγελμα μουσικοθεραπείας, μουσική ψυχοθεραπεία, προσωπική ψυχοθεραπεία

ARTICLE

A neuroscience-based rationale for patient-preferred live music as a receptive music therapy intervention for adult medical patients: A literature review

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ABSTRACT

Although patient-preferred live music (PPLM) is a frequently utilised receptive music therapy intervention, a neurological rationale for this treatment does not yet exist. The current paper reviews existing literature and proposes several potential neurologic rationales for PPLM as a receptive music therapy intervention for neurotypical adult patient populations. Additionally, the authors discuss gaps in the current research and make suggestions for further inquiries. The term 'patient-preferred live music' is parsed into four separate components: music, familiarity/preference, choice/autonomy, and live performance. The authors searched relevant neuroscience and music therapy literature to find research concerning each of these components. Results indicated extensive neuroscience research regarding the brain's neurologic response to music, mostly pertaining to the reward system and the process of dopamine release. Additionally, the authors found evidence to suggest that exposure to familiar stimuli and the act of making a choice may both be neurologically reinforcing. Research regarding the mirror neuron system may be a vital entry point from which to begin investigating the live and social aspects of PPLM. Further music-specific and neuroscience research is required to confirm these hypotheses. While various researchers have investigated individual components of PPLM, there is a lack of basic music therapy and neuroscience research regarding the paradigm as a whole. Further investigation is warranted.

AUTHOR BIOGRAPHIES

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INTRODUCTION

In their systematic review of patient-preferred live music with adult medical inpatients, Silverman, Letwin and Nuehring operationally defined patient-preferred live music (PPLM) as "a receptive music

therapy experience involving music selected and preferred by the patient that is performed live by a qualified music therapist" (Silverman, Letwin & Nuehring, 2016, p. 2). The researchers analysed eight PPLM-based studies meeting inclusion criteria and noted results were consistently positive in support of the use of PPLM. The researchers found evidence to support PPLM, when delivered by a qualified music therapist, as an applicable intervention for affective states including pain and nausea as well as physiological measures for adult cancer and transplant patients. However, with an understanding that there is no existing neuroscience-based literature that supports the PPLM model as a whole, the present paper aims to: 1) dissect the term 'patient-preferred live music' and provide potential neurologic explanations for the effectiveness of each of its components; 2) highlight limitations of current literature; and 3) suggest directions for future research. As music therapy becomes an increasingly relevant field, researchers, clinicians, and consumers must pursue a neurologic rationale for specific interventions, seeking to answer *why* certain practices are successful in an effort to use them most effectively. Vital to this understanding is an awareness of *how* music therapy interventions may function to affect neural change and alter behaviours, cognitions, and affective states.

MUSIC AS A NEUROLOGIC REWARD IN PPLM

At the basis of understanding the effectiveness of PPLM is a simple – yet incredibly complex – inquiry: how does the human brain respond to music? Several researchers have investigated the activation of the neurologic reward system in response to music listening, focusing much of their research on the release of dopamine. Central to this process are the Nucleus Accumbens (NAc) and the Ventral Tegmental Area (VTA) (Berridge & Robinson, 2003; Blood & Zatorre, 2001; Kelley & Berridge, 2002; Koelsch, 2014; Menon & Levitin, 2005). Dopaminergic neurons, located in the VTA, are projected through the mesolimbic pathway, eventually arriving in the medial forebrain bundle and supplying structures of the limbic system and the NAc (Siegel & Sapru, 2015).

Blood and Zatorre (2001) conducted a positron emission tomography (PET) study and identified a correlation between VTA activation and intensity of pleasurable responses to participant-selected music. In PET scans, the researchers observed increases in cerebral blood flow in the ventral striatum, left dorsomedial midbrain, right thalamus, and anterior cingulate cortex, all areas associated with reward, emotion, and arousal. In this study, the researchers did not explicitly state whether the musical selections presented were live or recorded, though contextual cues may be used to infer that the music was pre-recorded. This highlights the importance of reporting guidelines to increase transparency in music-based interventions (Robb, Burns & Carpenter, 2011). The authors of these guidelines advised that when recorded music is utilised, the researcher should "specify placement of playback equipment and the use of headphones vs. speakers," in addition to describing "who determined/controlled volume," and the "decibel level of music delivered and/or use of volume controls to limit decibels" (Robb, Burns & Carpenter, 2011, p. 4). Implementation of these reporting guidelines can provide valuable information for clinicians and investigators when attempting to use and generalise research.

Menon and Levitin (2005) completed an investigation similar to that of Blood and Zatorre (2001), citing the importance of studying this process with advanced and more accurate fMRI technology. In this study, the researchers reported utilising digitised sound files in the "music" and "non-music" conditions. The music condition contained short excerpts from songs in the classical music canon,

while the control condition utilised "scrambled" version of the same songs which the researchers manipulated to maintain pitch and loudness while removing any sense of musical continuity or predictability. The researchers found evidence suggesting that passive music listening stimulates a network of structures in the mesolimbic system involved in reward processing. Structures including the NAc, VTA, hypothalamus and insula work in tandem to regulate the brain's response to rewarding stimuli. The researchers found a positive correlation between NAc reaction to music and release of dopamine in the VTA. This study reaffirms the findings of Blood and Zatorre (2001), this time utilising the high resolution of the fMRI to measure and observe the activation of the Nucleus Accumbens. Menon and Levitin (2005) further suggested that passive music listening may provide an effective way to explore the neural mechanisms of anhedonia in patients with mental health disorders, as well as potential dysfunctional responses in the NAc, VTA, insula, hypothalamus, and orbitofrontal cortex, all of which are implicated in processing affect.

Dopamine release, in addition to immediately affecting reinforcement pathways and reward processes, has meaningful implications for cortical development. Researchers have demonstrated that a combination of dopamine release in the VTA and sensory stimulation results in cortical remapping, an influential component in reward processing and reinforcement learning (Bao et al., 2001; Chanda & Levitin,2013). As noted by Stegemöller (2014), it is generally accepted that dopamine plays an integral role in neuroplasticity. She suggests, "music therapists may be providing an enhanced learning environment for non-music tasks/behaviours through music-stimulated dopaminergic mediated neuroplasticity mechanisms" (p. 217). Additionally, Altenmüller and Schlaug (2015) highlighted the importance of the neurotransmitter *serotonin* in brain plasticity. While dopamine triggers feelings of pleasure resultant from unexpected or novel stimuli, serotonin triggers feelings of satisfaction from expected stimuli, both vital processes in reinforcement learning.

Music listening is not the only activity that works to stimulate the mesolimbic reward pathway. Researchers demonstrated that increases in dopamine levels in the VTA and NAc also occur in response to primary rewards like food or water and even act as a reinforcing effect for some addictive drugs (Berridge & Robinson, 2003; Kelley & Berridge, 2002). The same structures activated by music are likely to be activated in response to other euphoria-inducing stimuli, including eating, drinking, sexual behaviour, and using certain drugs of abuse. These selective circuits, including structures such as the NAc, VTA, periaqueductal gray, brainstem, and parts of the hypothalamus, may provide positive reinforcement associated with these rewarding activities (Blood & Zatorre, 2001; Siegel & Sapru, 2015). As early as 1980, Goldstein found that the music-activated neurologic pleasure response could be blocked by the opioid agonising drug naloxone. Goldstein's finding suggests that the pathway mediating musical reward response could be the same conduit that reinforces opioid use. Although there is a dearth of contemporary research specific to the relationship between musical reward and opioid-activated pathways, musical activation of reward circuitry may have meaningful implications in the treatment of drug addictions.

In addition to the wide body of research regarding dopamine release in response to music listening, some researchers have suggested a relationship between music listening and changes in autonomic response. It has long been hypothesised that regulatory functions including heart rate and respiration, which are largely mediated by the hypothalamus, may respond to pleasurable music listening (Blood & Zatorre, 2001; Goldstein, 1980; Krumhansl, 1997). In their fMRI study, Menon and

Levitin (2005) observed increased activation in the hypothalamus in response to pleasant music. The authors cited high correlations not only between NAc and VTA responses, but also between NAc and hypothalamic responses. They further suggested a "tight link" (p. 182) connecting the affective and cognitive systems, proposing meaningful implications for understanding human emotional and physical responses to music. Koelsch (2014) confirmed this notion in his meta-analysis of studies on music-evoked emotions, citing numerous researchers who observed increased activity in the hippocampal region in response to music listening. These findings aligned with another study by Koelsch and colleagues (2006), wherein the researchers found that a network of limbic and paralimbic structures (including the amygdala, hippocampus, parahipocampal gyrus, and temporal poles) responded to musical stimuli containing emotional valence, both pleasant and unpleasant. Based on their findings, the researchers suggested the effectiveness of music to regulate neuronal activity in this network of structures, in both an inhibitory and excitatory capacity.

FAMILIARITY AND PREFERENCE IN PPLM

Patient preference is a vital component of PPLM. Although there is evidence to support the use of familiar music in music therapy, neuroscience research about the relationship is scarce. Stegemöller (2014) advocates the use of preferred music when attempting to increase dopamine release in the listener's reward centre. Mitchell, MacDonald and Brodie (2006) found that patient-preferred music resulted in a "significantly greater feeling of control over a painful experience" (p. 348) and greater negative effect on mood disturbances than other distraction conditions during an autologous stem cell transplantation procedure. In an initial meta-analysis of music in medical and dental settings, Standley (1986) suggested the use of music therapy interventions utilising patient-selected or preferred music to act as an *audioanalgesic*. The author found evidence to suggest that music, especially when used in conjunction with other medical anaesthetics or analgesics, may be effective in reducing pain, anxiety and stress in a wide variety of patient populations. The researcher also noted the potential of patient-preferred receptive music to enhance chemical effects, thus reducing the amount, duration or side effects of medication administration, and possibly even shortening the length of hospitalisation. A majority of the studies included in Standley's meta-analysis utilised recorded music listening, and patient diagnoses ranged from neonatal care to cancer and dental procedures. Dependent variables included a variety of physiological measures including pulse rate, stress hormone levels, muscle relaxation and blood pressure, as well as affective states such as pain and anxiety perception. Several of the studies analysed by Standley noted the inverse effect of music on the amount of analgesic medication requested or administered.

Additionally, O'Kelly et al. (2013) found that for healthy control participants, live performance of preferred music resulted in the greatest positive effect on EEG amplitude when compared with improvised live music entrained to respiration, digital recording of disliked music, and white noise. It is important to note, however, that for healthy control data reported in this study, participants were instructed to keep their eyes closed, potentially minimising any effect of the live/social components of the musical stimulus and limiting the investigation to the patient preference aspect. Furthermore, the researchers found significantly increased EEG amplitude associated with preferred music for the experimental group of patients in vegetative and minimally conscious states, as well as increased

blink rate in response to preferred music within the group of patients in a vegetative state. Although this research adds to the growing rationale for further study of PPLM, it cannot necessarily be generalised to the larger population, most of whom do not fall into the same clinical context.

It is possible that the familiarity of patient-selected music makes it especially stringent in the therapeutic setting, even if the music therapy consumer is not conscious of this preference. In an early study, Wilson and Zajonc (1980) found that participants reliably discriminated between familiar and unfamiliar stimuli, even if the stimuli themselves were not consciously recognised. That is, if participants heard stimuli that they had been exposed to in the past, even if not conscious of their recognition, they still reported preference for familiar over new stimuli. Relatedly, Redish (2013) described the brain's memory storage system in terms of "pattern completion" (p. 259), wherein the brain's content-addressable memory system uses existing neural connections to retrieve large amounts of information with just partial content. With minimal information about the stimulus itself and with relatively little cognitive processing required, participants may feel and react more positively toward stimuli they have heard before than that which is unfamiliar. This seemingly subconscious preference for familiar stimuli over unfamiliar may contribute to the impact of PPLM in the therapeutic setting.

Using Perlovsky's (2007) "knowledge instinct" as a framework, Koelsch (2015) explained how possessing an understanding of the structure of a musical piece may result in feelings of pleasure or reward. A familiar song fulfils a person's inherent desire to understand, and thus they experience it as rewarding. Koelsch continues by hypothesising that this would potentially activate the dopaminergic reward pathway, although he noted that this has not yet been empirically supported. The familiar structure of a preferred song might lead to an increased dopaminergic response, thus making the song more rewarding to the listener.

Although outside the scope of this paper, it should be noted that the process of auditory stimulation itself and the expectedness of familiar music may have important implications for the motor system. Thaut (2015) describes how the auditory system is extensively connected with motor centres in the brain at cortical and subcortical levels. The author explains how firing of auditory neurons, upon rhythmic and musical stimulation, entrains motor neuron firing. As a result, the motor system is primed "toward a state of readiness to move" (p. 258). Although constituting older research, other investigators utilising EEG demonstrated the priming and activation of muscle groups in response to rhythmic and musical stimuli via reticulospinal pathways (Paltsev & Elner, 1967; Rossignol & Jones, 1976). This relationship between familiar musical stimuli and neurologic response, though it may be supported from a behavioural standpoint, has yet to be studied empirically in terms of dopamine release in the mesolimbic pathway. Further study through a neuroscience lens may result in a deeper understanding of this process.

CHOICE AND AUTONOMY IN PPLM

In their review of PPLM for adult medical patients, Silverman, Letwin and Nuehring (2016) noted the sense of autonomy that is afforded a patient who receives PPLM. First, the patient has the opportunity to initially accept or decline music therapy services. For a patient in a medical setting who likely has few opportunities for choice, the act of making this initial decision may be empowering in itself.

Moreover, the authors claimed that by choosing preferred music and having the opportunity to manipulate certain features of the music therapy session, patients may perceive themselves as in control of their environment. This, too, would likely induce feelings of empowerment and autonomy. Similarly, psychological researchers have long suggested the positive influence of choice on behavioural performances such as learning and memory tasks (Iyengar & Lepper, 1999; Perlmuter, Monty & Kimble, 1971; Setogawa, Mizuhiki, Matsumoto, Akizawa & Shidara, 2014). In a recent study, Setogawa et al. (2014) suggested self-choice was critical in that when a participant chooses a task rather than being instructed to complete it, that task's value might be enhanced. This enhanced value could actually function to improve the participant's performance on a memory or learning task.

In a classic study, Perlmuter, Monty and Kimble (1971, p. 49) reported that participants' performance was less disrupted when being "forced" to learn two competing sets of materials (A-B, followed by A-C) than when they were able to choose the first set of material and forced to learn the second. That is, when an opportunity for choice was given, then taken away, their performance on the task was more negatively affected. The researchers continued by suggesting that people who "have the opportunity to choose their own responses…may learn faster than subjects who do not exercise choice" (Perlmuter, Monty & Kimble, 1971, p. 52). Iyengar and Lepper (1999) found that Anglo-American students performed better on anagram tasks when given the choice of which puzzle to complete than when they were not given a choice. When told their mother or the experimenter chose the puzzle, the students performed significantly worse on the task. In contrast, Asian-American participants actually performed better when told the task was chosen for them by their mother. Motivation in response to self-choice may in fact be a cultural phenomenon. It is possible that socio-cultural factors play a vital role in the understanding of and reaction to perceived autonomy. Future research concerning this factor is warranted.

Neuroscientific research regarding exactly why the action of making a choice may be neurologically rewarding is scarce. Redish (2013) identified the importance of the nucleus accumbens (NAc) in both the deliberative decision-making and reward systems. This particular brain structure is vital in the processing of both evaluation of choices and reward. The NAc receives information from the hippocampus about past experiences and potential future outcomes and uses this information to evaluate the options presented. According to Redish, the NAc includes cells that "respond to reward consumption, as well as other cells that respond to cues that predict rewards, and other cells that seem to represent the expected value of an outcome" (Redish, 2013, p. 81). Only further neuroscience research can determine if the NAc or other brain structures perceive decision-making as a reinforcing experience, and if this is in fact dependent on cultural background, as suggested by Iyengar and Lepper (1999).

LIVE AND SOCIAL ASPECTS OF PPLM

Several music therapy researchers found results indicating patient preference for live music over recorded music in receptive music therapy interventions (Bailey, 1983; Cassileth, Vickers & Magill, 2003; Silverman, Letwin & Nuehring, 2016; Standley, 1986). In Bailey's (1983) study of 50 hospitalised patients with cancer, subjects who experienced live singing and guitar playing reported significantly less anxiety and greater vigour than the control group that heard tape-recorded performances. In

Standley's (1986) meta-analysis, the researcher suggested the significance of using live music, rather than pre-recorded music, to improve patient physiological and affective states, citing the importance of music therapists' ability to manipulate musical elements in response to patient state. Both the live component of PPLM and the social reinforcement of receiving a face-to-face music therapy intervention may be vital to its effectiveness. Koelsch (2015) explains the importance of social contact as a basic human need and potential for music as a conduit for social cognition, including "figuring out intentions, emotions, desires, and beliefs of other individuals" (p. 198). This aligns with Cassileth, Vickers and Magill's (2003) finding that live music therapy more effectively reduced pain and had a greater impact on mood when compared to a non-structured recorded music listening condition. The social aspects of a live musical interaction may play a major factor in the effectiveness of PPLM for improving mood states, when compared with recorded music listening.

The growing base of neuroscience research involving the mirror neuron system may have a profound influence on the developing neurologic rationale for PPLM. This system consists of a set of visuomotor neurons in the ventral premotor cortex that are activated in response to both performed and observed actions (Rizzolatti & Craighero, 2004). Mirror neurons were initially discovered in the monkey ventral premotor cortex, but there is substantial evidence to suggest the presence of analogous neuronal structures in the fronto-parietal regions of the human brain (di Pellegrino, Fadiga, Fogassi, Gallese & Rizzolatti, 1992; Gallese et al., 1996; Molenberghs, Cunnington & Mattingley, 2012; Rizzolatti et al., 2001; Rizzolatti, 2005). Mirror neurons appear to be implicated in both processing and comprehending human motor actions. Furthermore, they may be related to higher-level processes such as imitation, language and empathy (Molenberghs, Cunnington & Mattingley, 2012; Rizzolati, 2005; Wan, Demaine, Zipse, Norton & Schlaug, 2010). Koelsch, Fritz, Cramon, Müller and Friederici (2006) found that music listening activated motor areas implicated in the creation of vocal sounds. In their fMRI study, the researchers observed activation in the brain areas representing vocal production, even when participants were simply listening to music they perceived as pleasant.

Although there is limited empirical research on the topic, the salience of PPLM may be attributed to a process referred to as *emotional resonance* or *emotional contagion* (Juslin & Västfjäll, 2008; Koelsch, 2015). Acknowledging the lack of research on this particular subject, Koelsch (2015) theoretically discusses several different aspects of this process, wherein an individual perceives an emotion, be it a sound, a gesture or a facial expression, and mirrors or mimics the same emotion either internally, externally or both. The author explains the example of people listening to music that they perceive to be joyful. The listeners then embody 'joyful' music by smiling, singing along or moving with the music. In turn, this motor feedback actually evokes a feeling of joy. The author also discusses this process at the neuronal level, describing the process of sounds modulating arousal via the limbic pathway. Additionally, the author discusses the human mechanoreceptors, Pacinian corpuscles, which may become stimulated by musical sounds and thus lead to affective change.

Similarly, Juslin and Västfjäll (2008) outlined potential implications of the mirror neuron system in the process of emotional contagion, describing a situation in which a "voice-like" cello moves a listener to "experience the same sad emotion" (p. 565) expressed by the musical selection. De Gelder, Snyder, Greve, Gerard and Hadjikhani (2004) described a phenomenon where seeing body language expressing "fear" led to increased activity in brain areas associated with both motor processing and emotion. This connection between observed motor actions and emotional response may have

meaningful implications for understanding the importance of live music in music therapy interventions. Juslin and Laukka (2003) noted that music commonly imitates emotional speech, and Juslin's (2001) Super-Expressive Voice Theory suggests that humans are particularly attuned to the voice-like characteristics of music due to the neural response to such stimuli. In the medical music therapy setting, this theory of emotional contagion might translate to the music therapist using tools such as words, facial expressions, gestures and vocal inflection to create an ideal atmosphere for the patient's emotional wellbeing.

Perhaps as a result of the mirror neuron system and the process of emotional contagion, the listener may automatically and subconsciously mirror the emotion she or he perceives in a live musical stimulus. Presumably, a live music therapy experience such as PPLM would provide an even stronger basis of emotional stimuli for the listener to perceive and mirror. However, there is scant empirical research regarding the relationship between the mirror neuron system and emotional contagion, even without the added variable of music. Given further research specific to the music therapy domain, these findings may add to the growing research base supporting the use of live music therapy interventions, as opposed to recorded music listening such as music medicine.

CONCLUSIONS

Based on the existing music therapy literature, it appears that PPLM is a preferred and effective receptive music therapy intervention for improvement of affective states in adult medical patients (Silverman, Letwin & Nuehring, 2016). PPLM, however, like many other music therapy interventions, has yet to be explored from a neuroscience-guided perspective. In order for the evidence base and the music therapy field to grow, clinicians and consumers should continue pursuing neurologic explanations for the active change mechanisms of specific music therapy interventions. This paper calls attention to several potential neurologic explanations for the effectiveness of PPLM by breaking the intervention up into its individual components and reviewing the existing literature related to each of these components. However, the current research alone is not sufficient to empirically support the use of PPLM. The basic music therapy research required to rationalise the entire PPLM paradigm does not yet exist.

Though numerous researchers have explored individual aspects of PPLM, there is minimal literature regarding PPLM as a whole intervention. For instance, there is substantial evidence to support the neurologically rewarding nature of music via various dopaminergic and autonomic responses, but that alone does not necessarily justify the use PPLM (Berridge & Robinson, 2003; Blood & Zatorre, 2001; Kelley & Berridge, 2002; Koelsch, 2014; Menon & Levitin, 2005; Stegemöller, 2014). Similarly, some researchers have studied the patient preference aspect of PPLM without approaching the question of live versus recorded music (Blood & Zatorre, 2001; Menon & Levitin, 2005), while others focused on live versus recorded music without including the variable of patient preference (Bailey, 1983; Standley, 1986; Cassileth, Vickers & Magill, 2003). Furthermore, there is extremely limited neuroscience research available regarding the perceived reward value of choice/autonomy, and music therapy researchers have yet to study this topic in relation to PPLM. The comprehensive research on this topic that does exist, including the study by O'Kelly and colleagues (2013), delves into only three of the four components of PPLM, and is so specific to a specialised clinical setting that it cannot be

appropriately generalised to a neurotypical population. Lastly, these numerous facets of PPLM lack the solid neuroscience backing to connect them all.

The existing research, although it lays an initial foundation, is insufficient to rationalise PPLM from a neurologic standpoint. Future research might examine the relationship between mirror neurons, music, and emotional contagion, as well as the specific differences in processing live versus recorded preferred music in adult neurotypical populations, and the neurologic reward processes relating to choice and autonomy. In the contemporary era of heightened accountability and evidence-based practice, basic research is warranted and may help to justify the use of PPLM and differentiate it from other non-music therapy approaches like music medicine.

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Ελληνική περίληψη | Greek abstract

Ένας βασισμένος στη νευροεπιστήμη συλλογισμός που αφορά τη ζωντανή μουσική που προτιμάται από τους ασθενείς ως μια δεκτική μουσικοθεραπευτική παρέμβαση για ενήλικες ασθενείς: Μια βιβλιογραφική επισκόπηση

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ΠΕΡΙΛΗΨΗ

Παρόλο που η ζωντανή μουσική που προτιμάται από τους ασθενείς (patient-preferred live music, PPLM) χρησιμοποιείται τακτικά ως παρέμβαση δεκτικής μουσικοθεραπείας, δεν υφίσταται ακόμη μια νευρολογικά βασισμένη επιχειρηματολογία για αυτήν την παρέμβαση. Το παρόν άρθρο εξετάζει την υπάρχουσα βιβλιογραφία και προτείνει διάφορες πιθανές νευρολογικά βασισμένες αιτιολογήσεις για την PPLM ως μια παρέμβαση δεκτικής μουσικοθεραπείας για νευροτυπικούς ενήλικους πληθυσμούς ασθενών. Επιπλέον, οι συγγραφείς συζητούν για τα κενά στην τρέχουσα έρευνα και κάνουν προτάσεις για περαιτέρω διερευνήσεις. Ο όρος «ζωντανή μουσική που προτιμάται από τον ασθενή» αναλύεται σε τέσσερα ξεχωριστά στοιχεία: μουσική, οικειότητα/προτίμηση, επιλογή/αυτονομία, και ζωντανή απόδοση/εκτέλεση. Οι συγγραφείς αναζήτησαν τη σχετική νευρολογική και μουσικοθεραπευτική βιβλιογραφία για τον εντοπισμό έρευνας σχετικά με καθένα από αυτά τα στοιχεία. Τα αποτελέσματα έδειξαν εκτεταμένα νευροεπιστημονικά ερευνητικά δεδομένα σχετικά με τη νευρολογική απόκριση του εγκεφάλου στη μουσική, κυρίως σχετικά με το σύστημα ανταμοιβής και τη διαδικασία της απελευθέρωσης της ντοπαμίνης. Επιπλέον, οι συγγραφείς βρήκαν ερευνητικά τεκμήρια που υποδηλώνουν ότι τόσο η έκθεση σε γνώριμα ερεθίσματα όσο και η πράξη της επιλογής μπορεί να ενισχύονται νευρολογικά. Η έρευνα σχετικά με το σύστημα των κυττάρων

καθρεφτών [mirror neuron system] ίσως είναι ένα ζωτικό σημείο εισόδου από το οποίο μπορεί να αρχίσει η διερεύνηση των ζωντανών και κοινωνικών πτυχών της PPLM. Απαιτείται περαιτέρω έρευνα σχετικά με τη μουσική συγκεκριμένα και με τη νευροεπιστήμη για την επιβεβαίωση αυτών των υποθέσεων. Ενώ διάφοροι ερευνητές έχουν μελετήσει μεμονωμένα συστατικά της PPLM, υπάρχει έλλειψη βασικής μουσικοθεραπευτικής και νευροεπιστημονικής έρευνας σχετικά με την πρακτική αυτή στο σύνολό της. Δικαιολογείται έτσι η ανάγκη για περαιτέρω έρευνα.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

patient-preferred live music, νευρολογική, νευροεπιστήμη, μουσικοθεραπεία, εγκέφαλος

ARTICLE

Application of the Helping Model on music therapy practice for individuals with alcoholic use disorder: Theoretical orientation and empirical implication

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ABSTRACT

Research in the field of music therapy and substance-related disorders is growing and diverse within the intended treatment areas and interventions. Evidences of music therapy on this population have been focused on the effects of particular music therapy technique(s) or generalised responses from participants without establishing any theoretical treatment model. The application of music therapy within a solid treatment model based on thorough theoretical orientation is essential to any recovery or rehabilitation programme. This paper establishes the theoretical and empirical implications of music therapy based on Gerard Egan's Helping Model (2013) in treating patients with substance-related disorders, in particular alcohol use disorder (AUD). Egan suggested three principle goals of helping: (1) life-enhancing outcomes; (2) learning self-help; and (3) prevention mentality. This paper will explore whether the therapeutic goals in Egan's Helping Model can be addressed and established at the forefront of a music therapy treatment model for individuals with AUD and introduces empirical music therapy interventions with a case study based on the Helping Model.

AUTHOR BIOGRAPHY

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INTRODUCTION

In order for music therapy to be considered a mental health care profession, the therapeutic outcomes of music therapy must be agreed upon by major streams of other health-related professions. To fulfil this ultimate goal, the music therapy profession needs to adopt the general scientific research method including: theory development, theory examination, and clinical application. The processes of theory formation and clinical application are the most likely to produce reliable knowledge regarding therapeutic outcomes and the effects of treatment. As a music therapy researcher and clinician who

has been working with clients with substance-related disorders (i.e. alcohol use disorder) and mental illnesses, including anxiety disorder and depression at a university-affiliated music therapy clinic in a southwest region of the USA, I have developed a strong responsibility to justify the use of music in clinical practice and to improve the way of reporting therapeutic outcomes.

Evidence of music therapy on this population was focused on the effects of particular music therapy techniques or an overly generalised response to musical activities without establishing any systematic treatment model. As a result, the application of music therapy has not reached its full potential in clinical recovery practice for individuals with substance-related disorders. Therefore, the purpose of the present study is to establish a theoretical orientation and empirical implication of music therapy based on a cognitive behavioural treatment model in treating patients with alcohol use disorder. A music therapy case study of one client with alcohol dependence, depression, and drug addiction will be discussed.

Alcohol use disorder (AUD)

Alcohol use disorder (AUD) is the most common substance-related disorder in the USA. It is a combination of alcohol-related medical conditions characterised by alcohol dependence or alcohol abuse (American Psychiatric Association, 2013). It is more commonly referred to as alcoholism. AUD is defined by a cluster of behavioural and physical symptoms which can include withdrawal, tolerance, and craving of alcohol. It is often associated with problems similar to those associated with other substances (e.g. cannabis, cocaine, heroin, amphetamines, sedatives, hypnotics or anxiolytics). Symptoms of conduct problems, depression, anxiety, and insomnia frequently accompany heavy drinking and sometimes precede it. The diagnostic features of AUD highlight major areas of life functioning deficits involved in vocational performance, interpersonal relationships and health. Depending on the actual compound, AUD may lead to various medical problems, social problems, morbidity, injuries, violence, death, motor vehicle accidents, homicides, suicide, physical dependence or psychological addiction.

AUD can induce symptomatology which resembles mental illness; this can occur both in the intoxicated state and also during the withdrawal state (American Psychiatric Association, 2013). The psychiatric health impacts include susceptibility to depression, dysthymia, mania, hypomania, panic disorder, phobias, generalised anxiety disorder, personality disorders, drug use disorder, schizophrenia and suicide. Impairments in working memory, cognitive processing, emotional signals, executive functions, visuospatial abilities, gait and balance are also effects of AUD (Carigulo, 2007).

Treatment for alcohol use disorder

Alcohol dependence or alcohol abuse requires consistent and adaptable treatment schemas in order for an individual to successfully reduce or eliminate the desire to utilise alcohol (American Psychiatric Association, 2013). Behavioural interventions and medications exist that have helped many people reduce or discontinue their alcohol abuse and dependence. Behavioural psychology and several evidenced-based interventions have emerged: behavioural marital therapy, motivational interviewing, a community reinforcement approach, exposure therapy, and contingency management. In children

and adolescents, cognitive behavioural therapy (CBT) and family therapy currently have the most research evidence for the treatment of alcohol use problems. These treatments can be administered in a variety of different formats, each of which has varying levels of research support (Hawkins, Catalano & Miller, 1992).

Psychological treatments for alcoholism or alcohol dependence are typically composed of three phases: management of alcohol withdrawal syndrome, motivation for and initiation of abstinence, and prevention of relapse (Conroy et al., 2008). Treatment can occur once the client has portrayed a readiness and willingness to change, and is willing to be an effective participant in the changing process. Various therapies may be employed to reach a successful outcome, as well as pharmacological efforts. All of these approaches are viable methods to treat AUD but may be contingent on the individual's specific qualities and background. Kielcolt, Aggen and Kendler (2013) reported that genetic factors suggesting a risk for alcohol dependence overlap with genetic factors influencing a sense of mastery. The researchers define mastery as congruent with self-efficacy, sense of control, locus of control, or the belief that one has control over one's outcomes. Mastery has been found to be an indicator of the level of education attained, as well as having positive effects on lifestyle choices. Though mastery is partly heritable (thus genetic), environmental factors may also play a role. Kielcolt, Aggen, and Kendler (2013) concluded that women in particular had lower self-perceived mastery scores than did men that correlated inversely with alcohol dependence. The study suggests that interventions geared toward increasing or raising mastery levels and self-efficacy within alcohol dependence may aid in the treatment process (Kielcolt, Aggen & Kendler, 2013).

In order for individuals with AUD to be motivated for treatment, they must first be aware of their state and the need to change. Luft (1984) defines self-awareness as the knowledge and understanding of feelings, behaviours and interactions. Self-awareness and motivation are effective goal areas to eventually demonstrate a readiness for change (Duval & Wicklund, 1972; Silverman, 2012). A theoretical construct has indicated motivation to be a prerequisite for any successful treatment (Beckman, 1980). Goals of motivation typically require clinicians to focus treatment on identifying triggers and recommending healthy coping skills. Duval and Wicklund's (1972) objective self-awareness theory has determined that enhancing self-awareness can encourage motivation and self-evaluation. It was also demonstrated that an increase in self-awareness was more likely to achieve consistent behavioural changes measured by the individual's self-report (Pryor et al., 1978). These researchers indicated that creating an environment for self-awareness with self-focusing stimuli leads to self-evaluation. Hoyer and Heidenreich (2000) reported that psychological functioning as a whole was increased in a detoxification clinic due to increasing self-awareness from the beginning of treatment until its conclusion. Duval and Silvia (2001) suggested when individuals internally self-analyse their expectations regarding improvement, and their self-perceived outcomes are unfavourable, these individuals will avoid self-focus. Likewise, if these individuals perceived the rate of progress toward improvement to be low in relation to the magnitude of the problem, self-focus was also avoided. If the perception of improvement (i.e. self-efficacy or a sense of mastery) is sufficient, the individuals will likely take action and achieve desired behavioural changes (Duval & Silvia, 2001).

Morin (2011) identified that self-discrepancy is not only an indication of avoidance of self-awareness, but the defining factor between the real self and the ideal self. The discrepancy formed between the real self and the ideal self might result in avoidance of self-awareness; and the effort of

reducing discrepancy by modifying both the real self and the ideal self might produce positive outcomes and a higher rate of progress (Morin, 2011). This positive outcome occurs as a result of motivational factors created by the individual. In general, a person who is self-aware, and whose current self is discrepant from his or her desired self, would be motivated to change his or her current self in order to fit a personal standard of correctness (Duval, 1971). Silvia (2012) called this particular self-evaluating capacity "self-focus" and stated it is generated by the individual's potential motivation. One's expectation that the behaviour changes will fulfil the discrepancy and the needs is a potential motivation (Brehm & Self, 1989; Silvia, 2012). Positive environmental stimuli were capable of influencing an individual to become a self-observer with a great level of self-focus and self-awareness. Self-reports made under a self-focused condition with positive environmental stimuli are more likely to achieve consistent behavioural change (Pryor et al., 1978).

The treatment goals and approach for AUD need to be established upon the specific disorders or problems in the individuals while also considering their strengths and interests. Social skills are significantly impaired in people suffering from alcoholism due to the neurotoxic effects of alcohol on the brain, especially the prefrontal cortex area. Social skills training adjunctive to an inpatient treatment of alcohol dependence is probably efficacious, including managing a positive social environment (Alcoholics Anonymous, 2001). Therefore, treatments for AUD demand a strong client-therapist relationship to accomplish a particular aspect of behaviour fuelled by methods to achieve sobriety, readiness to change and the elimination of psychosocial stressors for further alcohol dependence (Conroy et al., 2008). The successful treatment for AUD should primarily establish therapeutic goal areas of self-awareness leading to motivation and readiness for change in a positive social environment with self-focusing stimuli (Beckman, 1980). Optimal therapeutic interventions might allow individual clients to be 'self-observers' and provide opportunities to develop a sense of mastery through increased motivation.

Music therapy for individuals with substance-related disorders

Music therapy facilitates various musical experiences designed to meet goals of self-awareness that lead to motivation and readiness for change in individuals with substance-related disorders (Silverman, 2012). Evidence-based clinical effects within those treatment areas have been reported (Ahamdi, 2001; Albornoz, 2011). Ross et al. (2008) conducted a naturalistic pilot study to determine if music therapy could affect treatment outcomes for individuals who were dually diagnosed with addiction and mental illness. Ross et al. concluded that music therapy could be a motivational tool for people in substance-related disorder rehabilitation. Silverman (2009) found that a lyric analysis intervention was as effective as verbal therapy in measuring treatment eagerness and working alliance in a detoxification unit. Mossler et al. (2012) measured certain music therapy techniques as a predictor for change in a mental health centre treating individuals with low motivation for therapy. Researchers concluded that positive tendencies toward improvement in interpersonal problems and social relationships occurred as a result of music therapy, particularly through singing or learning musical skills as a therapy (Mossler et al., 2012). Silverman (2011a) found that change readiness was increased and depression was decreased in a detoxification unit using music therapy.

In the realm of substance-related disorders, music can be utilised as an effective treatment medium to engage and facilitate self-awareness in patients. Silverman (2012) measured motivation and readiness for treatment in individuals with substance dependence using songwriting by converting song lyrics into codes within the Circumstances, Motivation, and Readiness for Treatment Scale (De Leon, 1993). By using a frequency count of certain words charged with certain meanings (e.g. "action" or "change"), the researcher was able to quantify responses into functional data collection of the individuals' awareness. Results of this study indicated that songwriting improved readiness rates, possibly because songwriting is an effective tool utilising music and lyrics as a medium to address topics pivotal to relapse prevention and to motivate the client to become self-aware by manipulating the manner in which issues are addressed (Silverman, 2012).

A positive reaction to musical stimuli may serve as an initial motivational factor for treatment within substance-related disorders. In another study conducted by Silverman (2011b) measuring change and depression of patients in a detoxification clinic, participants were either placed in a verbal therapy or music therapy session designed to determine readiness to change, level of depression, and treatment perceptions. Silverman found that those in the music therapy sessions demonstrated more statements of enjoyment, thankfulness and positive cognitive changes, and created a more comfortable environment to address sensitive issues such as triggers, social issues and previous relapses, as opposed to the verbal therapy group (Silverman, 2011b).

By creating an environment suitable for self-realisation, self-actualisation and self-awareness, individuals can transition into functional therapies focusing on behavioural change, behavioural restructuring and eventual sobriety without relapse. In order to begin, however, motivation is necessary for treatment. Individuals will only become motivated if they are aware of the deficits or need for change within themselves (Silverman, 2012). Music therapy is a beneficial therapeutic tool utilising music as a medium for redirecting the focus of individuals inwards to perceive the need for change, which induces motivation. Music therapy sessions construct a positive social environment for self-awareness through the use of music (i.e. self-focusing stimuli). Multiple functional interventions such as songwriting, lyric analysis and music listening can act as a useful environment to gain insight and awareness of the real self versus the ideal self to realise the need for change and to begin treatments.

The next section will introduce a cognitive-behavioural treatment model establishing the therapeutic goals of self-awareness, motivation, and readiness for change published in *The Skilled Helper: A Problem-Management and Opportunity Development Approach to Helping* (Egan, 2013); and an application of the model in music therapy interventions for individuals with AUD.

HELPING MODEL

Gerard Egan was born in Glasgow, Scotland and founded Developmental Eclecticism in the 1970s. Egan is the Professor of Organization Studies and Psychology and Programme Director for the Centre for Organization Development at Loyola University of Chicago. The skills-based model of therapy developed by Egan is an active, collaborative and integrative approach to client problem management. It shares some characteristics of the cognitive-behavioural school and is firmly grounded in the core conditions of the person-centred approach (Jenkins, 2000). Widely taught in counselling courses, the

model was first introduced by its author as a practical model for doing counselling; the model is pragmatic, change-oriented and specifies the appropriate skills available to the helper at different stages of the counselling process (Jenkins, 2000; Riggall, 2016). In a study of the sustainability of Egan's helping model, the trainees or supervisees of a social work practice were continuing to use most stages of the model with service-users or clients in a variety of settings. Further findings show that the model is still useful in situations where shared goals are set by social workers or counsellors, and the utilisation of role-play is the most embedded skill in the model for learning the optimal relationships with clients (Riggall, 2016).

Problem management and opportunity development

The helping model is a three-stage model or framework offered by Egan as useful in helping people solve problems and develop opportunities. The goals of using the model are to help people to "manage their problems in living more effectively and develop unused opportunities more fully" and to "help people become better at helping themselves in their everyday lives" (Egan, 2013, pp. 7-8). Thus, there is an emphasis on empowerment. In addition, the person's own agenda is central, and the model seeks to move the person toward action leading to outcomes which they choose and value. This model is not based on a particular theory of personality development or on a theory of the ways difficulties develop. It is a framework for conceptualising the helping process and is best used in working on issues in the recent past and the present.

Egan (2013) described a three-stage helping model: (1) Help clients explore their concerns: Current picture; (2) Help clients determine problem-managing outcomes and set goals: Preferred picture; and (3) Help clients draw up plans to accomplish goals: The way forward. He also described a therapeutic model for assisting clients in making the necessary and desired changes in their lives with the role of a 'helper'. Egan proposed that the three principle goals of helping are life-enhancing outcomes, learning self-help, and prevention mentality. According to Egan, an essential component in the helping process is the helping relationship itself. Egan (2013) also categorised and sequenced the therapeutic skills needed for the different phases of the helping process. The book's subtitle, *A Problem-Management and Opportunity-Development Approach to Helping*, addresses the goal of achieving positive outcomes alongside clients, ultimately guiding clients to help themselves. Because of Egan's unique approach toward the helping professions, its contents are applicable in all fields, whether in clinical work, the medical profession or any method of therapy. The following section is the summary of the three stages of Egan's Helping Model (2013).

Stage I: The current picture

Stage I of the helping model is the introductory step to helping and being helped. In this stage, helpers (i.e. therapists) encourage clients to acknowledge or consider their problems, issues, concerns and difficulties. Clients tell their stories (Task 1) and are subsequently encouraged to manage feelings of reluctance and resistance (Task 2). During Task 1, Egan addresses the need for helpers to start where the client starts, to encourage clients in the right direction. This contributes to the client's self-identity and overall awareness of the severity of their problem. This can be done by talking about the past to make sense of the present, to be liberated from it, and to prepare for action for the future. Finally, the

helper can enable the client to see problems as opportunities for change and spot previously unused opportunities.

In Task 2 of Stage I, the helper aids clients in managing reluctance and resistance. Egan noted that the seeds of reluctance are in the client, whereas the stimulus for resistance is external – in the helper or the social setting surrounding the helping process. Egan argues that reluctance can stem from a fear of intensity, lack of trust, fear of disorganisation, shame, the cost of change and loss of hope. Resistance to treatment occurs when clients feel that they need to resist help. From here, helpers guide clients in their search for value (Task 3). This is the step when helpers challenge clients to fully participate in the helping process. This requires clients to state that their problem is solvable and to accept challenges that can be turned into an opportunity or effectively managed.

Stage II: The preferred picture

There are three tasks in Stage II: (1) Help clients discover possibilities for a better future; (2) Crafting the change agenda: Help clients move from possibilities to choices; and (3) Help clients discover incentives for commitment to change their agenda. Stage II primarily functions as a trigger for action or as an antecedent for Stage III. During Task 1, it is important for the client to focus on their possible selves. In this task, the helper shows the client how to identify and develop an opportunity in order to manage a problem rather than solve it. This requires extensive creativity and brainstorming for both parties. Egan refers to the concept of divergent thinking, or "lateral thinking" to encourage possibilities for change. Task 2 helps the client move from possibilities to choices. This is where clients shape their goals by specifically relating the goal to a good intention. Egan summarises how goals should be shaped and initiated, including appropriate time frames for meeting goals and whether the goals are sustainable. Task 3 is designed to help clients commit to a better future. This task encourages client self-efficacy and helps clients evaluate their commitment to change and their pre-determined goals. All of these tasks function as a trigger for action and transition into Stage III.

Stage III: The way forward

Stage III is designed and aimed at problem-managing action steps for and by the client. This is considered to be the 'game plan' of the helping process. This stage is divided into three tasks: (1) possible strategies, (2) best-fit strategies, and (3) turning strategies into a realistic plan. In Task 1, strategies are implemented into previously initiated goals. Building strategies includes using a framework to build specific possibilities. Task 2 involves choosing the best-fit strategies for a client. This reassesses the client's ability to make effective decisions for their future. This is the way clients will ultimately accomplish their goals. Helpers can also guide clients in choosing the most effective strategies in terms of benefits, acceptability and the costs of the strategies. This leads the client to Task 3, to help clients formulate viable plans. In this task, Egan contends that the plans add value to the clients' change or need to change. Here, discipline must be developed but the implementation of plans can simultaneously keep clients from feeling overwhelmed. Better strategies can then be developed and a more specific shape of the plan can be carved out.

APPLICATION OF THE HELPING MODEL IN MUSIC THERAPY

Music therapy helping model in alcohol use disorder recovery

Egan's (2013) Helping Model can be applied to music therapy interventions as well as to the overall treatment process in music therapy for patients with substance-related disorders, particularly AUD. Egan developed a sequential design for the overall helping process but he noted that treatment can begin anywhere, and problems, goals and strategies may present themselves at unanticipated times. The overall model can be addressed with music therapy interventions, regardless of the order in which the client or case occurs. Music therapy encompasses the stimulus of musical elements in order to elicit changes in behaviour (Lim, 2008). Music can also be used to gain insight, awareness and knowledge of one's inner self when facilitated effectively (Ahamdi, 2011; Albornoz, 2011; Silverman, 2012). The therapeutic process of music therapy incorporates both the stimulus of music and the therapist as helpers. Although the design of music therapy allows music to elicit and facilitate changes in an individual, the therapeutic helping process is essential to its implementation. Without a strong client-therapist relationship and a therapeutic framework produced by the helper, the change may not take place. The following section is a music therapy application for the three stages of Egan's Helping Model.

Stage I: Current picture
Task 1. The story: Problem situations − Clients tell their stories.   Task 2: The real story: New perspectives − Manage feelings of reluctance and resistance.   Task 3: The right story: Key issues to work on − Search for value.   Stage I Music Therapy Application*: Fill-in-the-blank Songwriting.*
Stage II: Preferred picture
Task 1. Possibilities − Help clients discover possibilities for a better future.   Task 2. Goal/Outcomes − Help clients move from possibilities to choices.   Task 3. Commitment − Find incentives for commitment to change.   Stage II Music Therapy Application: *Lyric Analysis.*
Stage III: The way forward
Task 1. Possible strategies − Building strategies and a framework to build specific possibilities.   Task 2. Best-fit strategies − Choosing the most effective strategies.   Task 3. Plans to accomplish goals − Turn strategies into a realistic plan.   Stage III Music Therapy Application: *Songwriting and Relapse Prevention.*

Table 1: Summary of Egan's (2013) Helping Model and its application to music therapy

Music therapy application: Stage I current picture

During Stage I, a music therapist may implement certain interventions to encourage the client to tell her story, develop perspectives and accept challenges regarding alcohol dependence. At this stage, a music therapist may use a variety of musical elements to gain information. A standard intervention is fill-in-the-blank songwriting. By choosing a song whose lyrics demonstrate themes of awareness, the alcohol use problem or feeling of inner self, the client is able to use existing words as a prompting method to generate their own perspective and story of their problem, to fill in blanks. This may act as a springboard for further discovery of the problem and reveal that others have also been in this situation.

Example: Fill-in-the blank songwriting. Lyrics from *Waiting On The World To Change* by John Mayer

Me and all my _____
Are all misunderstood
They say I stand for nothing
And there's no way I ever could
Now I see everything that's going wrong
With _____
I just feel like I don't have the _____
To rise above and _____.

Music therapy application: Stage II preferred picture

During Stage II, the music therapist addresses possibilities for the client and defines or narrows choices. From there, the client also helps to discover incentives for change. In a music therapy setting, this stage can be addressed with lyric analysis, songwriting, music as a reward, or reconstructive efforts at identifying the problem. Lyric analysis provides the client with a tool by which he/she may identify his/her needs, wants and desires. By addressing certain lyrics and applying them to a real situation, the client can choose his/her response or choice more clearly. Songs often indicate the result of choices or feelings, and deeper analysis followed by specific questions regarding the lyric material can aid the client in realising the choices he/she wants to make. In a lyrical analysis of a song addressing the artist's path or story, the client can quickly identify parts of himself/herself he/she may want to change.

Example: Lyric analysis post questions from *I'll Be There* by Jackson 5

1. Who is there for me in times of trouble?
2. Who am I there for in times of trouble?
3. Do I wish I could be there for others?
4. Does my current addiction prevent me from being the person I want to be?
5. What can I do better or differently to be there for someone else?
6. What prevents me from being there?

Music therapy application: Stage III the way forward.

In Stage III, the music therapist guides the client to implement effective strategies and formulate a relevant and specific plan for change. This may become a long-term struggle of maintenance and relapse prevention when paired with alcohol dependence. In order for the client to develop specific strategies and a plan to overcome the problem of alcohol dependence, he/she must first gain insight into his/her problem and realise the need for change, using methods to find possibilities. Stages I and II fuelled these steps and consequently led to Stage III. In a music therapy setting, this stage may rely heavily on music as a reward for correct behaviour as well as an alternative choice to alcohol dependence. In this setting, a music therapist may plan for the client to listen to his/her favourite music only if he/she refrained from drinking alcohol that day. It may also be used as a device to prevent relapse by listening to music or writing music in place of drinking. This requires advanced methods of self-control, and music must be perceived as a stronger stimulus than alcohol for this plan to be effective. Active music engagement during a session may also function as a reward or method for abstinence from alcohol. This includes playing or making music. One way to implement this strategy is to direct the client to keep a journal of his/her behaviour, whether it is thoughts of alcohol, actual intake of alcohol or feelings of being unmotivated. This can then function as the lyrics to a songwriting session with the music therapist, where these situations are given meaning and purpose. It also allows for thoughts to be externalised and addressed directly. In addition, songwriting requires individuals to independently initiate and identify internal discrepancies, choices and thoughts to become externalised and acknowledged.

Example: Songwriting from *What a Wonderful World* by Louis Armstrong.

I see _____, _____ too
I see _____for me and you.
And I think to myself, what a _____world.
I see _____ and _____
The _____ and the _____
And I think to myself, what a _____world.
The _____, _____
I hear _____, saying, "_____."
They really saying, "_____."
I hear _____, I _____
They'll _____.
And I think to myself, what a _____world.

These examples are only a few interventions that may be used for this population in a psychiatric music therapy setting. Each intervention can be tailored to the needs of an individual by utilising their music preferences, skills and their own words to create meaningful results. Music can act as a self-focusing stimulus, reward or functional medium of exchange for ideas and thoughts that may otherwise be difficult to elicit in a therapeutic setting. If the music therapist includes Egan's suggestions of active listening, responding with empathy, understanding, probing and challenging clients it creates the potential for effective therapy. By using functional methods of music alongside

therapeutic skills, achievable goals and strategies can be addressed and explored in treating individuals with AUD.

An essential component described by Egan (2013) in the helping process is the helping relationship itself. According to Egan, the helping process should be a partnership characterised by empathy and respect. The helper involves the client in as much of the therapeutic process as possible. In music therapy, this can translate into sharing goals and objectives with clients, or even helping them choose their own. Egan's helping model can indeed be applied to music therapy treatment for individuals with AUD. An empirical implication on integrating Egan's model to music therapy and its impact will be discussed throughout a case study of a female with alcohol dependence and depression/anxiety in the next section.

CASE STUDY

Client S was a 60-year-old female diagnosed with alcohol dependence and secondary depression. The client had been dependent on alcohol for approximately 20 years, and had concealed her problem from family members and friends until one year prior to beginning music therapy. The client demonstrated criteria stated in the DSM-V for alcohol dependence. Client S had been previously diagnosed with alcohol dependence, depression and drug addiction (Xanax). The client was taking medication for her depression and was involved in Celebrate Recovery, a Christian-centred 12-step Alcoholics Anonymous (Alcoholics Anonymous, 2001) group that met weekly. Client S was in Step 4 of the programme, titled *Made a Searching and Fearless Moral Inventory of Ourselves* at the time of the present study. This step focuses on internal awareness and motivators for external actions. This may include relationships with family members, personality, past history or present struggles dealing with any of these. She was referred to music therapy services by a family member who was concerned with her ability to remain sober.

The purpose of this case study was to demonstrate the author's clinical work with a client with AUD and to explore the effect of music therapy on self-awareness, motivation and readiness for change. Five treatment goals were established in the study: (1) improve self-awareness; (2) improve motivation; (3) establish readiness for change; (4) decrease anxiety; and (5) identify opportunities for self-control. Measurements were taken over the course of eight weeks, and the five goal areas (i.e. self-awareness, motivation, change, anxiety and self-control) were targeted and measured over the eight-week study. Data were collected during at least five sessions for anxiety, six sessions for self-awareness, motivation or change, and four sessions for self-control. Some of the weeks included two interventions whereas others included only one. This is due to the fact that some interventions were lengthier or a specific area was targeted due to the client's self-report.

Assessment of the client in two music therapy sessions demonstrated possible treatment areas for the ultimate goal of sobriety, prevention of relapse and for continual motivation to remain sober. These treatment goal areas are:

1. To establish/improve self- awareness
   a. (Later, motivation and readiness for change were added)
2. To decrease anxiety (as a symptom of depression)

3. Identify opportunities for self-control

For client S in particular, these goals served as functional treatment areas coinciding with the three stages of Egan's (2013) helping model and the 12-step programme goals of AA, of which both end goals are sobriety and prevention of relapse (Alcoholics Anonymous, 2001).

Music therapy treatment areas

Goal 1: To increase self-awareness, motivation and readiness for change.

Objective: Given a self-awareness exercise, the client will identify (either verbally or written) her current emotional state, current motivational level and current desire for change, and differentiate it from her past or future state, level or desire 80% of the time with unlimited prompts from the music therapist.

Treatment Goal 1 was to establish or improve self-awareness within the context of substance abuse or dependence. In order for the client to become fully aware of her choices, decisions, level of coping and possible triggers for temptation or relapse, she had to first establish her abilities and deficits either by self-report or by other measurable indications of awareness. The songwriting technique was used to address this objective. The measurable evidence was constructed by converting song lyrics into codes within the Self-Awareness, Motivation and Readiness for Change. By using a frequency count of certain words charged with certain meanings (e.g. "action" or "change"), the music therapist was able to quantify responses into functional data collection for client S's awareness. Songwriting has improved Readiness for Change rates possibly because songwriting is an effective tool utilising music and lyrics as a medium to bring forth topics pivotal to relapse prevention and to motivate the client to become self-aware by manipulating the manner in which issues are addressed, that is, with musical stimuli (Silverman, 2012). The three stages of Gerard Egan's helping model (2013): (1) The current picture: Help clients explore their concerns, (2) The preferred picture: Help clients determine problem-managing outcomes and set goals, and (3) The way forward: Help clients draw up plans to accomplish goals, were integrated in the contextual measurement of the case study. Egan's three principle goals of helping: life-enhancing outcomes, learning self-help, and prevention mentality were established in each music therapy session addressing Goal 1.

Statements made by the client throughout each session were categorised as either indicators of Self-Awareness, Motivation or Readiness for Change. A content analysis was created to categorise the client's responses as indications of one of these three functional areas. Subcategories, including "reflection", "emotion", "responsibility", "ideal", "self-esteem", "action" and "change" were established to further evaluate the client's progress in each major category and used to represent a particular aspect of the stages that are necessary in order for client S to reach change (Silverman, 2012). For example, "reflection" serves as a major area for acknowledging a discrepancy between the client's "real self" and "ideal self". "Ideal," under the Motivation category, serves as a sub-category to measure responses that appeared motivational because of a prior acknowledgement of self-awareness.

After considering multiple options for categorising the responses of client S, the format in Table 2 was used for data collection of the client's responses during music therapy interventions, as well as in verbal discussions surrounding the music therapy interventions.

Self-awareness motivation change

Session	Reflection	Emotion	Responsibility	Ideal	Self-esteem	Change	Action	Total
3								
4								
5								
6								
7								
8								
9								
10								
Total								

Table 2: Data collection format for Goal 1: To establish/improve self-awareness

Goal 2: To decrease anxiety.

Objective: Given an improvisational exercise, the client will identify her present anxiety using a Likert-scale rating verbally, before and after the exercise.

The client's self-perceived anxiety levels were also measured for four sessions. Anxiety measurements were taken in the form of verbal questions or prompts before and after musical improvisation questions. The criteria for the improvisation included: improvisation for at least two minutes; closed eyes during intervention; no talking during intervention. A Likert-scale was implemented and given to the client verbally, with 5 indicating the highest levels of anxiety and 1 indicating minimal/no anxiety. Examples of anxiety level were given in the form of sentences rather than numbers. The Likert-scale representations for levels of anxiety helped the client to most clearly and accurately define her anxiety level.

Likert-scale rating	Explanation
1	I don't feel any anxiety; I have forgotten that I was anxious in the first place.
2	I don't feel very much anxiety; I am enjoying the activity and have not changed my thoughts due to anxious feelings or thoughts.
3	I feel somewhat anxious; I am enjoying the activity but feel some anxiety.
4	I feel very anxious; I am participating but my anxiety is more dominant in my thoughts.
5	I feel extremely anxious; I can't focus on the activity due to my anxiety.

Table 3: Anxiety measurement Likert-scale for Goal 2: To decrease anxiety

Goal 3: To identify or improve opportunities for self-control.

Objective: Given a journal or writing activity, the client will identify and improve self-control, accurately identifying at least two moments of temptation and struggle within the past week.

The client was asked to indicate at least two instances of temptation or struggle during the week and record it in a journal. In an effort to externalise the temptations and identify opportunities for self-

control, music therapy interventions were then implemented (songwriting) based on the journal entries.

INTERVENTIONS

The following interventions were used during the case study to address each goal area (individual treatment plans in log).

Goal area	Intervention	Number of times goal was addressed in sessions
Self- awareness, motivation, readiness for change	Fill-in-the blank Song analysis Songwriting	5
Anxiety	Improvisation	5
Self-Control	Songwriting Music playing	3

Table 4: Goal areas and music therapy interventions

Sample procedures are provided for each intervention with the general outline and sequence of sessions below. With each intervention, different songs that were familiar or preferred by the client were used. Songs were chosen based on their content suitable for analysis as well as their relevance toward the client's situation. The selection of songs might imply the potential biases, however.

Fill-in-the-blank songwriting

1. The music therapist introduced and sang the song, *Just the Way You Are* by Billy Joel to the client.
2. The music therapist asked the client to fill in the blanks of missing words with her own thoughts of how she feels presently.
3. The music therapist then asked the client how she wants to feel, and asked her to fill in the blank for each prompt.
4. The music therapist supported the client in identifying issues of dissonance between present and future, and whether any wording should be changed after their discussion.

Improvisation

1. The music therapist introduced the xylophone to play.
2. The music therapist asked the client to rate her overall anxiety on the Likert scale, or in her own words.
3. The music therapist suggested to the client a few ways in which to play the instrument and provided a structure for improvisation.
4. The music therapist asked the client to focus only on the improvisational exercise and to continue playing until she felt that the song should "end".

5. The music therapist also asked the client to bring up any thoughts or expressions produced after playing the improvisational exercise, and how they relate to anxiety or anxiety-producing thoughts.

Songwriting

1. The music therapist asked the client if she had any temptations or struggles from the previous week.
2. The music therapist showed the client the song from last week and provided verbal support through the format of the song.
3. The music therapist continued to brainstorm with the client and guided the client through a songwriting method.
4. The music therapist created a melody for newly written lyrics within an original song.

RESULTS AND ANALYSIS

Goal 1: To increase self-awareness, motivation and readiness for change.

Figure 1 is a representation of the client's responses from sessions three to eight. Sessions one and two were assessment sessions and are not included in the data collection. The greatest amount of responses demonstrated "reflection" of either the client's situation, past, present or future. The least amount of responses was verbal indications of "responsibility". Though sessions typically focused on increasing self-awareness, other areas such as motivation and readiness for change were present in sessions as well and were calculated as part of the client's verbal statements regarding overall functioning. The qualitative results for Reflection, Emotion, Responsibility, Ideal, Self-Esteem, Change, Action and Termination are reported in the section below.

Qualitative analysis

Each subcategory is represented with direct quotes and dialogue that occurred during sessions. Italics denote a prompt whereas plain text denotes the client's own words.

Reflection

Fill-in-the-blank intervention (third session): The client was asked to identify herself using prepared prompts in response to listening to *Just the Way You Are*. The exercise sought to aid the client in gaining insight into how she views herself, and what thoughts may be produced with open prompts:

> *I pretend* to be happy when I'm not.
> *I am* non-confrontational.
> *I wonder* if I will get a job.
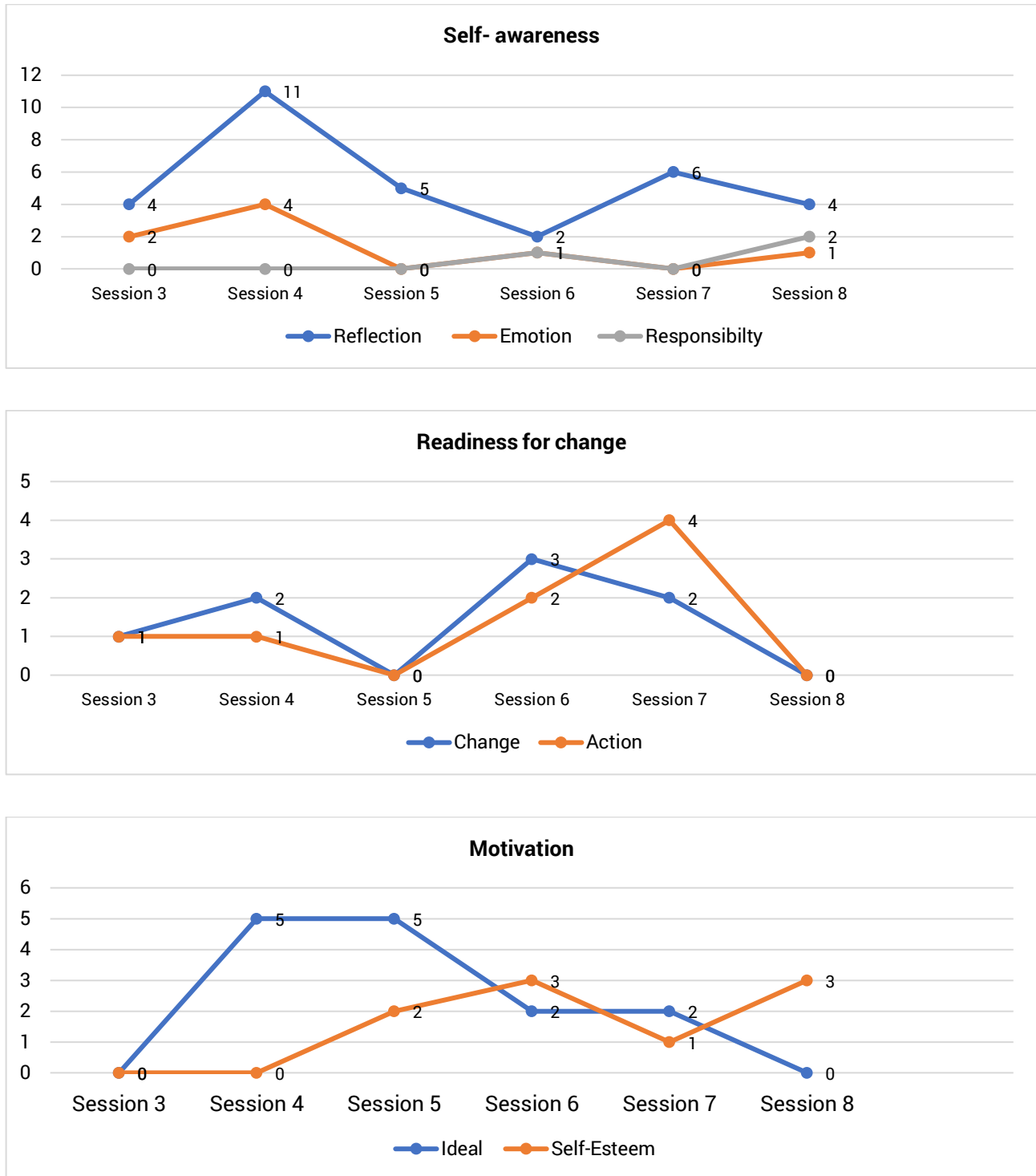> *I understand* life isn't always perfect.

Figure 1: Verbal responses during music therapy

Verbal Statement (fourth session): After asking the client what the intervention helped her to think about, the client reflected on her current employment situation. This led to a discussion of her relationship with her husband and his support of her:

> I still can't find a job. I just know it's because of my age. They are discriminating.
> I used to have a really good job and get paid a lot... I would feel better about being
> unemployed if my husband would just say it's ok. But I feel like my self-esteem

has been crushed because no-one will hire me and my husband tells me to keep looking. I wish I could be ok with staying home while I work on everything that's going on in my life, and that my husband would say that's ok too. Instead, during my downtime, it's hard not to think about alcohol.

Through verbal discussions with the client, she stated that her husband has not been supportive or even acknowledged her alcohol addiction. There had never been a discussion concerning her thoughts or actions pertaining to her addiction throughout their marriage, and she agreed that this was a factor needing serious evaluation. This led to identifying some of her anxieties and issues of self-esteem. Though the client was uncomfortable speaking to her husband, she knew she would have to initiate a discussion on the topic. However, this did not occur during the entire course of our meetings.

Emotion

Fill-in-the-blank intervention (fourth session): The client completed an exercise designed to increase her understanding of her real self versus her ideal self. It became apparent to the therapist that at times the client saw her past self or future (ideal) self as her true self. In an effort to produce thoughts of the client's present self, her emotion regarding her situation in the past began to surface.

I walked out this morning and "cried myself to sleep".
I remember "how much pain I was in".
I've seen "pain" and I've seen "gain".
I've seen sunny days that I thought "would never come again".
I've seen lonely times when I could not "concentrate".
But I always "thought I was strong to see me through".

Verbal statement (fifth session): The next week, the client was comfortable in expressing her feelings after returning from a weekend spiritual retreat. She relayed her anxious thoughts before and after her encounters with strangers who did not know her as an alcoholic and how she felt without anyone knowing of her addiction.

I was so unsure of whether I would have to tell everyone I was an alcoholic. I was going to introduce myself that way. I am so ashamed of it, but I thought that everyone there might hold me accountable. If there was going to be alcohol there, there's no way anyone would let me drink it, which is good for me. After the retreat though, my new friends told me I was an 'encourager' and 'motivator'. It meant so much to me for them to see that in me, because to myself I was an 'alcoholic'. I felt normal for once.

She stated that she was proud she had an identity that was not tied to her addiction. This was a pivotal moment for the client's self-image and for developing an accurate perception of her real self. Unfortunately, the client had hoped that the spiritual retreat would have, in a way, "cured" her from her addiction. Although during the weekend she did not experience any tempting thoughts, when she

returned it became difficult again. It became evident that the client was consistently seeking something other than herself to fix her problem. The client exhibited some denial in accepting the necessity of putting forth effort on her own.

Responsibility

Fill-in-the-blank intervention (second session): The client refers to her family as she fills in the blanks to identify her responsibility in the situation, and who may be responsible for her care:

> "We all" must make a pact; we must bring "me back".
> Where there is love, "we'll" be there.
> "You" reach out "your" hand to "me".
> "Hope you'll" have faith in all "I" do.
> "Thanks for your help, I'm getting there."

Verbal Statement (third session): For homework, the client was given a list of questions after a song analysis of "I'll be There". Her responses are below:

1. *Who is there for me in times of trouble?*

    My sons have been there for me. And my daughters-in-law, they are my saving grace.

2. *Who am I there for in times of trouble?*

    I try to be there for my kids, but it seems like they are taking care of me these days. I used to be able to help a lot of people at work. My pastor has told me to look into volunteering so I can feel needed again, but I don't know.

3. *Do I wish I could be there for others?*
    Yes. I feel like everyone has lost their faith in me. Especially with watching my own grandkids. I want to be able to watch them, and live long enough to see them grow.

4. *Does my current addiction prevent me from being the person I want to be?*

    Yeah, I feel so trapped, like it controls me. I just want something to keep me from being addicted. That's why I go to counselling and 'Celebrate Recovery'. I hear all of these stories of success and I want that too.

5. *What can I do better or differently to be there for someone else?*

    I could volunteer I think, and stay sober.

6. *What prevents me from being there?*

> My addiction.

This exercise demonstrated that the client had depended on others more than herself for effort, change and relapse prevention. Taking responsibility for her situation was also the least identified subcategory of self-awareness for the client. Oftentimes, the client would refer back to this exercise and place her "hope" in her family to help her. Though family support was and is vital to the client's success, the client's own effort is also necessary. The client also identified her addiction as the key factor that prevents her from "being there" for someone else. Rather than stating herself, or her choices, she chose to make her addiction the primary factor for not being able to help others. Responsibility is essential in increasing and maintaining a realistic view of one's self. The client struggled with this and despite the assistance of countless prompts, was never able to fully admit that she needed to produce effort for her own change.

Ideal

Songwriting: After a relapse, the client was asked to recount her thought patterns throughout the episode from beginning to end. After this, the client was asked to provide concrete motivations that could potentially prevent her from relapsing again. These motivations were embedded into an original song for easy memory if thoughts of relapsing occurred again. It also helped the client to identify simple and real motivators for change:

> Because I want to remember without effort.
> I want to see my grandkids grow.
> I want freedom from my own chains.
> And I want to use the grace God has bestowed.

Verbal statement: After relaying the relapse episode and writing her original song, the client discussed in more detail why her motivations led her to wanting to give up alcohol:

> I don't want my grandkids to be frightened of me. They won't want to be near a
> grandmother who is like that. And I want to be a great grandma. I want to be
> healthy for everyone so I don't miss anything, and so they can depend on me for
> things.

This exercise led the client to gain insight into her ideal self in a realistic and attainable manner. By outlining specific motivations that would lead her to change, the client was successful in viewing change as a worthy endeavour, and not changing as a problem. This is vital in producing change in oneself. Though the client had not yet found effort within herself to pursue these endeavours, it was the first time she identified to herself that it was necessary.

Self-esteem

Improvisation (fifth session): During an improvisational music activity, the client was asked to comment on anything that came to mind while playing music.

> I sound really good on this instrument! I can't believe I can keep up with you on this drum! You know, I always used to sing in my church choir, I used to love doing that.

Verbal statement: During the client's relapse, she reported that for the first time in her life, after buying alcohol, she drank only one sip and then stopped. After providing verbal support to the client on her improvements despite her relapse, the client reported her thoughts:

> I guess I didn't think of taking one sip as a good thing. I have been so ashamed this whole week. Like everything I worked for had been thrown out the window. But maybe I am making progress. I guess that makes me feel a little better about myself. I'm just telling myself that it won't happen again.

The client had a strong awareness of her lack of self-esteem. She provided many statements throughout improvisational interventions that relayed her need for building her self-esteem. Positive self-esteem statements usually involved her ability to produce pleasant-sounding music without any training. Music therapy exercises proved to be important in showing the client her strengths as a creative individual. The client's own relapse behaviour caused the biggest decrease in self-esteem. Her lack of communication with her husband concerning her addiction and unemployment also contributed to this. In order for motivation to improve, self-esteem was essential for providing a positive view of self and to view the pros of changing as more desirable then the cons of changing.

Change

Songwriting (seventh session): During this intervention the client discussed for the first time that her anxiety was a major cause of her alcoholism. After a brainstorming session with the music therapist, the client wrote original lyrics designed to find ways to change her perception of worry and anxiety:

> If I can live for today, don't look toward the future, my worries of family, slip-ups, and my purpose will all be nurtured. So I need to live in the present and be happy with my life, I have so much to be thankful for and should have no strife.

Verbal Statement (eighth session): For homework, the client was asked to identify her worries and then identify reasons why they are not worth worrying about.

> I realised I have a roof over my head, food to eat, a car that runs, and there is really no reason to worry about everything that could happen. Sometimes, yeah, I get worried even when my son doesn't answer his phone, but it's hard to live that way. Even in social situations I am naturally anxious. I used to turn to

alcohol but now I can't, but it still makes me think of drinking. I think if I had more
to do then I wouldn't think of worrying so much.

The client was aware of her anxieties from initial sessions but had never directly related it to her
addiction issues. The client was able to articulate a specific chain of events regarding her anxiety and
its effect on temptations. The client realised during this session that change must occur for her to
reduce temptations and, as a result, reduce relapses.

Action

Fill-in-the-blank intervention (assessment session): During the client's assessment, she was asked to
identify what actions she could or would take for relapse prevention. Although it was her first session,
she was able to identify action steps for her lifestyle changes.

> Now if I had the power to "change"
> I would have never "started drinking"
> No more "pills, alcohol"
> And when you trust your "enemies"
> What you get is what you got….
> So "I" keep waiting
> On "me" to change

Verbal statement (ninth session): In the final session the client identified multiple action steps
that would lead her to relapse prevention. These were all subjects discussed throughout all therapy
sessions:

> I've learned that I can't be alone. I need a hobby if I am really going to change.
> I've started going to a bible study and meeting friends there. I also know that if I
> start to worry, it acts as a trigger for wanting alcohol. I know I can play music
> now to help relax me. My unemployment has caused the most anxiety from day
> to day, and I think I am beginning to be ok with not having a job because I have
> a lot to work on for myself. I think this is the biggest part of my life right now
> (Alcoholism) that I need to focus on, so I'm doing everything I can.

Termination

Prior to the last two sessions it had been reported by family members that the client's relapses had
increased and that she was in need of intensive therapeutic care. The client avoided telling the music
therapist that these relapses were occurring, and had stated during those sessions that she had
remained sober. However, after the ninth session the client contacted the music therapist and said
she would be starting an inpatient 30-day Rehabilitation programme for alcohol and drug addiction.
The client's comments to her family and to the music therapist disclose her initiative to begin this
process:

> I am really scared, but I know I am doing the right thing. I have been having too
> many relapses. I need to go.

These relatively simple acknowledgements prove the client's realisation of herself and her need to change. True motivation is exhibited as a result of self-awareness. Further description of the client's progress is provided in the discussion.

Goal 2: To decrease anxiety

The duration of improvisation was increased every week to indicate a reduction in anxiety. Figure 2 depicts the client's self-perceived anxiety before and after an improvisation intervention. The client consistently had a reduction in anxiety after improvisational interventions as indicated by her self-perceived responses. After each session the client and therapist engaged in a discussion regarding anxiety, which was discussed as qualitative analysis.
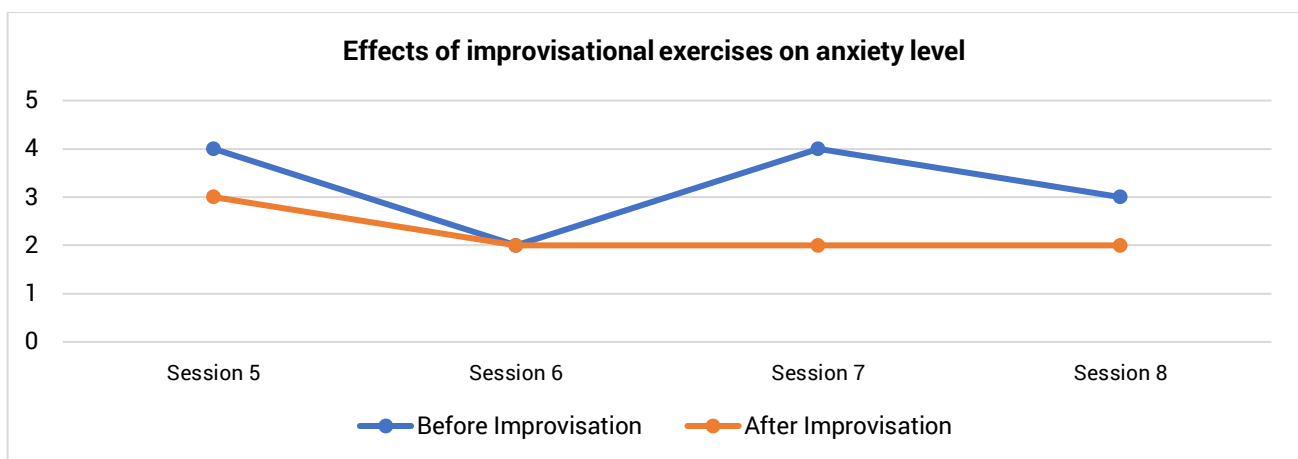

Figure 2: Effects of improvisational exercises on anxiety level

Goal 3: To increase self-control

The client was asked to identify at least two instances per week in which alcohol was a direct temptation, struggle or thought. The client was asked to record this in a journal and to provide these instances to the music therapist at each session. In response to each record, the music therapist implemented a songwriting intervention to acknowledge the incident and provide a memorable behaviour for reducing the temptation. The client only recorded in her journal one time and struggled to meet the criteria for this goal. Suggestions for this behaviour are included in the discussion.

EVALUATION OF MUSIC THERAPY TREATMENT

Overall, the client responded effectively to music therapy treatment. Results indicate that the client successfully increased identification of self-awareness, motivation and readiness for change. Improvisational interventions effectively facilitated reductions in anxiety. Each intervention demonstrated strengths for each goal area as well. It can be concluded that the strongest function of music within sessions for this client was to express interior thoughts of self-focus. This allowed the

client to gain self-awareness. For fill-in-the-blank activities in particular, the client could be guided toward successful conclusions given multiple prompts and semantic information in sentences directed toward the client's interior thoughts. This activity acts as a pivotal starting point for applying interior thoughts to an exterior art form, creating awareness of self as well as of one's surroundings (Albornoz, 2011). In initial sessions, the client was unable to articulate her true realisation of self. Through fill-in-the-blank activities the client began to acknowledge a discrepancy between who she was and who she wanted to be. By specifically incorporating lyrics that identify a tense (past, present or future) the client was guided to recognise her own self relative to her past, present and future situations (Egan, 2013). Fill-in-the blank activities established and facilitated Stage I: The current picture in Egan's Helping Model.

Other interventions such as lyric analysis or songwriting also enhanced goal outcomes. Lyric analysis provided the client with tools to identify her needs, wants and desires. This theme has commonly been found as a beneficial method for increasing self-awareness and readiness for change; therefore, song lyric analysis was exclusively implemented in Stage II: The preferred picture in Egan's Helping model. In lyrical analyses with the client, discussions were often guided toward acknowledgement of the client's story or current picture, which greatly aided in identifying parts of her she wanted to change. This allowed motivation to develop. Motivation naturally occurs as a result of realising a discrepancy between the real self and ideal self (Duval 1971). Although the client never reached an optimal level of motivation to permanently change, she began to recognise discrepancies through lyric analysis.

Songwriting created opportunities for the client to create an original template for her story, which required motivation. This particular application of music therapy might be essential for the problem management and opportunity development in Egan's helping model and optimally established in Stage III: The way forward. In order for the client to choose to resolve inner conflicts she had to be motivated by her recognition of self. Songwriting proved to be beneficial toward gaining an understanding of the client's motivation. Motivation is the result of the recognition of the need to change, which concerns later steps of action (De Leon 1993). Similar patterns were found within the client's songwriting results. When using songwriting in order to identify opportunities for self-control, the client was able to categorise her priorities, tell her story of a temptation and resolve her conflicts through identifying motivations. It was the client's responsibility to record these events over the course of each week. Even though moments of temptation were frequent and identifiable by the client, she was only able to complete this once. The client had not yet mastered the skills necessary for self-control or admitting temptation. Because relapses were intermittently occurring throughout the course of the sessions, the client had numerous opportunities to record her temptations, but chose not to.

Improvisation interventions were consistently effective for the client's anxiety and were also found to have a beneficial effect on the client's self-esteem, which is a subcategory of motivation. The client indicated improved self-esteem with regard to improvisation by realising her strengths as an individual apart from her identity as an alcoholic and gaining a greater sense of her motivation.

Responsibility was indicated as a subcategory of self-awareness. The client made the least gains within this subcategory. Upon close examination, a link can be established between the client's recurring relapses near the end of the study and the client's low outcome of responsibility for her actions. Acknowledging the discrepancy of the real self versus the ideal self is necessary for the client

to obtain fullness of change (Morin, 2011). Throughout sessions, the client demonstrated an avoidance of taking responsibility for her past, present and future; and this step is critical for all of the three stages in Egan's helping model. The client effectively reflected and identified emotional content for her situation, but never fully acknowledged that 'herself' was involved in her own problem. On numerous occasions the client suggested that she hoped someone else would be willing to make an effort to "fix her" or "help her". The client was uncomfortable in feeling confident that she could help herself. Conclusions for this thought process can also be made from her struggle with self-esteem and her distant, hopeful view of her ideal lifestyle. In order for the client to fully accept herself and become ready for change, she had to take responsibility for her discrepancy. This is the ultimate recognition of the real self (Prochaska & Prochaska, 2010). It creates an opportunity for self-help as well as a gateway for discussion of self-limiting thoughts (Egan, 2013).

A promising result from this study, despite the client's relapse, was her initial reason for admitting herself to a rehabilitation hospital. For the first time over the course of the study, the client told her family members that she was in need of help and needed to go on an intensive rehabilitation programme. In the year preceding this study the client was entirely guided by her family to receive help. However, by increasing her own self-awareness, she was able to finally take responsibility of her own future.

This client provided a gateway for initiating a systematic protocol for music therapy treatment within the AUD population. The present case study offers a method for quantifying responses into viable categories to measure success and potential predictors for change. The client's progress provides substantial material for effective interventions for particular goal areas. By utilising qualitative data to substantiate quantitative results, music therapy integrating Egan's Helping model can be seen as a beneficial tool for AUD rehabilitation. The results conclude that music therapy effectively facilitated an increase in self-awareness, motivation and readiness for change. Reductions in anxiety and opportunities for self-control are also observed with regard to this client. Although goal areas may be different for each patient of AUD, this case study provides the empirical approximation for music therapy treatment of a variety of goals a patient may have.

CONCLUSION

Music therapy treatments facilitated to address goals within the substance abuse population (e.g. AUD) are common and in demand. Many different interventions have been used to improve goal areas of these individuals though it is difficult to measure and recognise whether music therapy is an effective tool for treatment without establishing the therapeutic mechanism. Egan's helping model encompasses many aspects of current music therapy treatment processes for the clinical population and provides a framework for a systematic approach to the therapeutic mechanism including establishing goals and defining the optimal, yet practical, music therapist-client relationship. The theoretical orientation for the music therapy techniques such as fill-in-the blanks, song lyric analysis, songwriting or improvisation can be validated through the particular approach of problem management and opportunity development in Egan's book, *The Skilled Helper*. The empirical evidence demonstrated in Egan's three stage-helping model can be transferred to music therapy practice for this population. The three stages in Egan's helping model might be particularly useful for music

therapists to set therapeutic goals and objectives and to determine the scope of music therapy interventions.

Application of music therapy within the practical helping model of therapy developed by Egan can result in a theoretical and empirical understanding of the commonly used music therapy techniques for treating individuals with AUD. The therapeutic response to music (i.e. song lyric analysis) or music production (i.e. songwriting or improvisation) can be naturally embedded in the key therapeutic phenomenon and the relationship between the therapist and clients. The musical experiences and therapeutic relationships have the potential to strengthen the process and outcome of therapy. Music therapy practice incorporated in the helping model can potentially justify the effects of music or musical experience on enhancing the personal lives of the AUD population.

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Ελληνική περίληψη | Greek abstract

Η εφαρμογή του Βοηθητικού Μοντέλου [Helping Model] στη μουσικοθεραπευτική πράξη για άτομα με διαταραχή χρήσης αλκοόλ: Θεωρητικός προσανατολισμός και εμπειρικές επιπτώσεις

Hayoung A. Lim

ΠΕΡΙΛΗΨΗ

Η έρευνα στο πεδίο της μουσικοθεραπείας και των διαταραχών που σχετίζονται με ουσίες εξελίσσεται και ποικίλλει εντός των προβλεπόμενων θεραπευτικών περιοχών και παρεμβάσεων. Τα αποδεικτικά στοιχεία της μουσικοθεραπείας σε αυτήν την πληθυσμιακή ομάδα έχουν επικεντρωθεί στις επιδράσεις συγκεκριμένων τεχνικών μουσικοθεραπείας ή γενικευμένων ανταποκρίσεων από τους συμμετέχοντες, χωρίς να καθιερώνουν ένα θεωρητικό μοντέλο θεραπείας. Η εφαρμογή της μουσικοθεραπείας μέσα σε ένα μοντέλο σταθερής θεραπείας βασισμένη σε λεπτομερή θεωρητικό προσανατολισμό είναι απαραίτητη για κάθε πρόγραμμα αποκατάστασης ή επανόρθωσης. Αυτό το άρθρο καθιερώνει τις θεωρητικές και εμπειρικές επιπτώσεις της μουσικοθεραπείας με βάση το Βοηθητικό Μοντέλο [Helping Model] του Gerard Egan (2013) για τη θεραπεία ασθενών με διαταραχές που σχετίζονται με ουσίες, ιδίως τη διαταραχή χρήσης αλκοόλ (alcohol use disorder, AUD). Ο Egan πρότεινε τρεις βασικούς στόχους βοήθειας: (1) αποτελέσματα που βελτιώνουν τη ζωή, (2) μάθηση της αυτοβοήθειας, και (3) νοοτροπία πρόληψης. Αυτό το άρθρο θα διερευνήσει εάν οι θεραπευτικοί στόχοι του Βοηθητικού Μοντέλου του Egan μπορούν να επιτευχθούν και να καθιερωθούν στην πρωτοπορία ενός μουσικοθεραπευτικού μοντέλου θεραπείας για άτομα με AUD και να εισαγάγει εμπειρικές μουσικοθεραπευτικές παρεμβάσεις μέσω μιας μελέτης περίπτωσης βασισμένης στο μοντέλο Βοηθητικό Μοντέλο.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

διαταραχή χρήσης αλκοόλ [alcohol use disorder], μουσικοθεραπεία, ανάρρωση, Βοηθητικό Μοντέλο [Helping Model]

ΑΡΘΡΟ

Διαφοροποιημένη διδασκαλία στη μουσική εκπαίδευση: Απόψεις και προβληματισμοί καθηγητών μουσικής πρωτοβάθμιας εκπαίδευσης

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ΠΕΡΙΛΗΨΗ

Η διαφοροποιημένη διδασκαλία αποτελεί μια σύγχρονη μέθοδο διδακτικής προσέγγισης η οποία στοχεύει στην καλύτερη εκπαίδευση των μαθητών με ειδικές εκπαιδευτικές ανάγκες. Με την εφαρμογή διαφοροποιημένης διδασκαλίας, το μάθημα της μουσικής αγωγής μπορεί να ενισχύσει την ανάπτυξη δεξιοτήτων και να συμβάλει στη γνωστική και κοινωνικο-συναισθηματική πρόοδο των συγκεκριμένων μαθητών. Στόχος της παρούσας μελέτης ήταν να διερευνηθούν οι απόψεις των εκπαιδευτικών μουσικής αγωγής, οι γνώσεις τους αλλά και το επίπεδο προετοιμασίας που διαθέτουν σχετικά με τη διαφοροποιημένη μορφή μάθησης. Για τον σκοπό αυτό πραγματοποιήθηκαν ημι-δομημένες συνεντεύξεις με εν ενεργεία εκπαιδευτικούς μουσικής αγωγής πρωτοβάθμιας εκπαίδευσης σε σχέση με πρακτικές διαφοροποιημένης διδασκαλίας στο σύγχρονο ελληνικό σχολείο. Από τα αποτελέσματα της έρευνας καταδεικνύεται η ανάγκη για ενίσχυση του έργου των εκπαιδευτικών μουσικής και ορίζεται αναγκαία η περαιτέρω διερεύνηση του θέματος στον ελλαδικό χώρο.

ΒΙΟΓΡΑΦΙΕΣ ΣΥΓΓΡΑΦΕΩΝ

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ΕΙΣΑΓΩΓΗ

Το σύγχρονο σχολείο συμπεριλαμβάνει μαθητές με διαφορετικά μαθησιακά χαρακτηριστικά και επίπεδα ικανοτήτων, οι οποίοι χαρακτηρίζονται από έντονη διαφοροποίηση τόσο από κοινωνικής

και πολιτισμικής άποψης όσο και σχετικά με τις ακαδημαϊκές τους ικανότητες (Παντελιάδου, 2008). Ενώ διευρύνεται η ανάγκη για εσωτερική διαφοροποίηση κατά τη διδασκαλία, το μάθημα της μουσικής ορίζεται συχνά ως ένα από τα διδακτικά περιβάλλοντα που προσφέρονται για ένταξη μαθητών με ειδικές εκπαιδευτικές ανάγκες. Έτσι, οι συγκεκριμένοι μαθητές μπορούν να βρίσκονται στο περιβάλλον της τάξης του γενικού σχολείου και να συναναστρέφονται με τους συμμαθητές τους τυπικής ανάπτυξης (McDowell, 2010). Κατά συνέπεια, οι εκπαιδευτικοί μουσικής καλούνται να είναι επαρκώς και κατάλληλα προετοιμασμένοι ώστε να συμπεριλάβουν στο πλαίσιο της διδασκαλίας τους μαθητές διαφορετικών ικανοτήτων και να επιτύχουν την ομαλή ενσωμάτωσή τους στην τάξη, σύμφωνα με τις ειδικές εκπαιδευτικές ανάγκες που τυχόν έχουν.

Η διαφοροποιημένη διδασκαλία αποτελεί μία προσέγγιση που απευθύνεται σε όλους τους μαθητές μίας τάξης και ιδιαίτερα σε εκείνους που παρουσιάζουν ειδικές εκπαιδευτικές ανάγκες. Συγκεκριμένα, η διαφοροποιημένη διδασκαλία αφορά τον κατάλληλο σχεδιασμό της διδασκαλίας δίνοντας έμφαση τόσο σε όλους τους μαθητές όσο και στο αναλυτικό πρόγραμμα (Παντελιάδου, 2008). Κατά τη διαφοροποιημένη διδακτική προσέγγιση, ο εκπαιδευτικός προσπαθεί να δώσει κίνητρο για μάθηση μέσα από ένα μεγάλο εύρος ενδιαφερόντων και εφαρμόζοντας διάφορες διδακτικές τεχνικές (Tomlinson, 2014). Με αυτόν τον τρόπο, οι μαθητές έχουν τη δυνατότητα να διδαχθούν μέσα σε ένα εξατομικευμένο πλαίσιο που μπορεί να αποφέρει καλύτερα αποτελέσματα για τον καθένα ξεχωριστά. Ταυτόχρονα, οι διαφοροποιήσεις στο περιεχόμενο και τη διαδικασία της διδασκαλίας επιτρέπουν σε όλους τους μαθητές της τάξης να απολαμβάνουν μαθησιακά οφέλη και να παρουσιάσουν πιθανή βελτίωση στην ακαδημαϊκή τους απόδοση (Tomlinson, 2003).

Η εφαρμογή της διαφοροποιημένης διδασκαλίας στη μουσική αγωγή συνιστά μια ενδιαφέρουσα και δημιουργική εκπαιδευτική προσέγγιση. Σύμφωνα με τον Lubet (2011), η μουσική μπορεί να αποτελέσει την πύλη για τη συμπερίληψη των μαθητών με ειδικές εκπαιδευτικές ανάγκες στη γενική τάξη, δεδομένου πως το μάθημα της μουσικής είναι σημαντικό για τη στήριξη και τη συναισθηματική ενίσχυση των μαθητών. Επιπλέον, σύγχρονες έρευνες καταδεικνύουν πως μέσω του μαθήματος της μουσικής αγωγής και με κατάλληλη διδακτική προσέγγιση, μπορούν να ενισχυθούν οι δεξιότητες μαθητών με ΔΕΠΥ (McAllister, 2012), μαθητών που ανήκουν στο φάσμα του αυτισμού (Colwell & Thompson, 2000· Detty, 2013), μαθητών με κινητικές αναπηρίες (Nilsson, 2014), μαθητών με προβλήματα στην ανάγνωση (Register et al., 2007), καθώς και μαθητών με συναισθηματικά προβλήματα και προβλήματα συμπεριφοράς (Detty, 2013). Ομοίως, πρόσφατες μελέτες στον ελληνικό χώρο τονίζουν τον θετικό ρόλο της μουσικής στην εκπαίδευση των ατόμων με ειδικές ανάγκες (Καρτασίδου & Σούλης, 2000· Καρτασίδου & Τσίρης, 2007)

Σκοπός της παρούσας έρευνας ήταν να διερευνηθούν οι τάσεις και απόψεις Ελλήνων εκπαιδευτικών μουσικής σχετικά με τη διαφοροποιημένη διδασκαλία στο πλαίσιο του μαθήματος της μουσικής. Κύριοι θεματικοί άξονες των συνεντεύξεων αφορούσαν τις γνώσεις των συμμετεχόντων εκπαιδευτικών μουσικής, το επίπεδο προετοιμασίας που διαθέτουν σχετικά με τη διαφοροποιημένη μορφή μάθησης, καθώς και τις πρακτικές διαφοροποιημένης διδασκαλίας που εφαρμόζονται στο σύγχρονο ελληνικό σχολείο. Η έρευνα προσφέρει προβληματισμούς για τον εξελισσόμενο ρόλο των εκπαιδευτικών μουσικής στην ένταξη μαθητών με ειδικές εκπαιδευτικές ανάγκες στο σύγχρονο ελληνικό σχολείο.

ΜΟΥΣΙΚΗ ΑΓΩΓΗ ΚΑΙ ΔΙΑΦΟΡΟΠΟΙΗΣΗ ΤΗΣ ΔΙΔΑΣΚΑΛΙΑΣ

Διαφοροποιημένη διδασκαλία

Οι μαθητές με ειδικές εκπαιδευτικές ανάγκες αποτελούν ένα ανομοιογενές και ιδιόμορφο υποσύνολο των μαθητών σε μία γενική τάξη. Συνήθως, παρουσιάζουν ικανότητες αλλά και ιδιαίτερες ανάγκες κατά την εκπαίδευσή τους (Darrow, 2012). Σύμφωνα με τις σύγχρονες παιδαγωγικές προσεγγίσεις, ο εκπαιδευτικός καλείται να διαφοροποιήσει και να προσαρμόσει τη διδασκαλία του, ώστε όλοι οι μαθητές της τάξης να μπορούν να ανταποκριθούν σε αυτήν, ανάλογα με τις δυνατότητες του καθενός ξεχωριστά.

Σύμφωνα με την Tomlinson (2014), στη διαφοροποιημένη διδασκαλία κάθε διδακτικό αντικείμενο παρουσιάζεται στους μαθητές με διαβάθμιση δυσκολίας και μέσα από διαφορετικά υποστηρικτικά συστήματα. Έτσι, η διαφοροποιημένη μορφή μάθησης στηρίζεται στο ότι ο εκπαιδευτικός δεν πρέπει να απευθύνεται στον μέσο μαθητή της τάξης, αλλά να σχεδιάζει δραστηριότητες διαβαθμισμένης δυσκολίας ανάλογα με τις ικανότητες και ιδιαιτερότητες του κάθε μαθητή. Βέβαια, αυτή η εφαρμογή της διδασκαλίας προϋποθέτει πολλαπλές διδακτικές προσεγγίσεις της ύλης του μαθήματος (McCord & Watts, 2006).

Άλλωστε, η διαφοροποίηση αποτελεί μια τεχνική στη διδασκαλία και τη μάθηση που σέβεται τις ατομικές ιδιαιτερότητες του κάθε μαθητή. Σύμφωνα με την προσέγγιση αυτή, ο κάθε μαθητής έχει τη δυνατότητα να μάθει μέσα από τρόπους που ταιριάζουν στις προσωπικές του ανάγκες και ιδιαιτερότητες και ο στόχος είναι να εφαρμοστεί ο κατάλληλος τρόπος προσέγγισης στο διδακτικό πλαίσιο για κάθε μαθητή (Παντελιάδου, 2013). Μάλιστα, όπως αναφέρει η Tomlinson (2014), το διαφοροποιημένο περιβάλλον της τάξης υποστηρίζει τους μαθητές που μαθαίνουν με διαφορετικούς τρόπους και διαφορετικούς ρυθμούς και οι οποίοι φέρνουν στο σχολείο διαφορετικά ταλέντα και ενδιαφέροντα. Έτσι, ο εκπαιδευτικός οφείλει να είναι προετοιμασμένος να αλλάξει και να προσαρμόσει τη διδασκαλία του ανάλογα με τις ειδικές εκπαιδευτικές ανάγκες του κάθε παιδιού κάνοντας τις απαραίτητες τροποποιήσεις, και να μη θεωρεί ότι ο μαθητής θα προσαρμοστεί από μόνος του σε έναν συγκεκριμένο τρόπο διδασκαλίας (Standerfer, 2011).

Διαφοροποίηση στη μουσική αγωγή

Η φύση του μαθήματος της μουσικής αγωγής είναι ευέλικτη και επιδέχεται εύκολα διαφοροποιήσεις και παρόμοιες πρακτικές, ανάλογα με τις συνθήκες και τις ανάγκες που παρουσιάζονται σε κάθε ομάδα διδασκομένων (Darrow & Belgrave, 2013). Αυτή η ευελιξία του μαθήματος της μουσικής αγωγής επιτρέπει την άμεση αλληλεπίδραση ανάμεσα σε ικανούς και λιγότερο ικανούς μαθητές. Για αυτόν τον λόγο, οι εκπαιδευτικοί μουσικής μπορούν να έχουν έναν σημαντικό ρόλο στην εκπαίδευση των μαθητών με ειδικές εκπαιδευτικές ανάγκες (McDowell, 2010).

Στο μάθημα της μουσικής αγωγής, το διδακτικό πλαίσιο μπορεί να διαφοροποιηθεί σε τρία επίπεδα: στο περιεχόμενο της διδασκαλίας, τη διδακτική μέθοδο και το τελικό προϊόν με το οποίο οι μαθητές αξιολογούνται και αποδεικνύουν την κατάκτηση της γνώσης (Standerfer, 2011). Ο προσεκτικός σχεδιασμός της διδασκαλίας είναι προϋπόθεση για να μπορέσει ο εκπαιδευτικός να

αποφασίσει τον τρόπο με τον οποίο το περιεχόμενο, η μέθοδος διδασκαλίας ή το προϊόν μπορούν να διαφοροποιηθούν. Κατά τον σχεδιασμό, ο εκπαιδευτικός οφείλει να λαμβάνει υπόψιν την αναγνωστική ικανότητα, το μαθησιακό προφίλ και τα ενδιαφέροντα του μαθητή (Standerfer, 2011).

Ένα σημαντικό στοιχείο στη διαφοροποίηση είναι ότι η κατάκτηση του προϊόντος της διδασκαλίας πρέπει να αποδεικνύεται με ποικίλους τρόπους. Μέσα από μια τέτοια διαδικασία, ο εκπαιδευτικός μπορεί να γίνει πιο ενεργός και παιδαγωγικά πιο αποδοτικός (Darrow, 2012). Ο εκπαιδευτικός που εφαρμόζει διαφοροποιημένη διδασκαλία δεν αρκείται μόνο στην παραδοσιακή προσέγγιση της διδασκαλίας για κανένα μαθητή με ή χωρίς ειδικές εκπαιδευτικές ανάγκες. Αντίθετα, ερευνά καινούριες πρακτικές και τεχνικές, οι οποίες τον ωθούν να γίνει πιο δραστήριος κατά τη διδασκαλία. Συνεπώς, σχεδιάζοντας μια πορεία διδασκαλίας που στηρίζεται στη διαφοροποιημένη προσέγγιση, ο εκπαιδευτικός μουσικής αγωγής μπορεί να είναι πιο αποτελεσματικός και δημιουργικός για όλους τους μαθητές της τάξης και όχι μόνο για τους μαθητές με ειδικές εκπαιδευτικές ανάγκες (Darrow, 2012).

Προκειμένου να είναι η διαφοροποιημένη προσέγγιση επιτυχής, απαραίτητη προϋπόθεση είναι η κατάλληλη προετοιμασία και ενημέρωση του εκπαιδευτικού, ώστε να έχει την ικανότητα να ανταποκριθεί στις προκλήσεις και τις ευκαιρίες που δημιουργούνται μέσα από τη διαφοροποιημένη προσέγγιση της διδασκαλίας (McDowell, 2010). Ωστόσο, οι εκπαιδευτικοί μουσικής αγωγής εμφανίζονται παιδαγωγικά απροετοίμαστοι για να αντιμετωπίσουν και να υποστηρίξουν τους συγκεκριμένους μαθητές (Gooding, Hudson & Yinger, 2013). Τόσο σε προπτυχιακό όσο και σε μεταπτυχιακό επίπεδο, η προετοιμασία των εκπαιδευτικών μουσικής για την αντιμετώπιση μαθητών με ειδικές εκπαιδευτικές ανάγκες φαίνεται να είναι από περιορισμένη έως ανύπαρκτη (Καρτασίδου, 2004· Καρτασίδου & Στάμου, 2006· Salvador, 2010). Κατά συνέπεια, η πλειοψηφία των εκπαιδευτικών μουσικής αγωγής δε γνωρίζει ουσιαστικά τι είναι η διαφοροποιημένη διδασκαλία, με αποτέλεσμα να μη γίνεται αξιοποίηση των πλεονεκτημάτων της διαφοροποίησης από τους εκπαιδευτικούς, και η διδασκαλία τους να μην μπορεί να ανταποκριθεί στις ειδικές εκπαιδευτικές ανάγκες όλων των μαθητών της τάξης (Whipple & VanWeelden, 2012).

Σκοπός της έρευνας

Σκοπός της παρούσας έρευνας ήταν να διερευνηθούν οι απόψεις των εκπαιδευτικών μουσικής πρωτοβάθμιας εκπαίδευσης, σχετικά με τη διαφοροποιημένη διδασκαλία. Αν και υπάρχει αυξανόμενο ενδιαφέρον στον ελληνικό χώρο σχετικά με τον ρόλο της μουσικής στην ειδική παιδαγωγική (βλέπε Καρτασίδου, 2004· Καρτασίδου & Τσίρης, 2007), μέχρι σήμερα δεν έχουν πραγματοποιηθεί συγκεκριμένες μελέτες πάνω στο θέμα της διαφοροποιημένης διδασκαλίας και τις απόψεις και γνώσεις των εν ενεργεία εκπαιδευτικών μουσικής. Μέσα από την παρουσίαση των απόψεων των εκπαιδευτικών μουσικής αγωγής, επιχειρήθηκε η ανάδειξη των παραγόντων που επιδρούν στη διαμόρφωση των αντιλήψεων σχετικά με τη διαφοροποιημένη διδασκαλία και στη στάση τους στην εφαρμογή διαφοροποιημένων προγραμμάτων. Επίσης, στόχος της έρευνας ήταν ο εντοπισμός και η καταγραφή των δυσκολιών με τις οποίες έρχονται αντιμέτωποι οι εκπαιδευτικοί μουσικής αγωγής στην προσπάθεια να διαφοροποιήσουν τη διδασκαλία τους, έτσι ώστε να προσδιοριστούν τρόποι αντιμετώπισης των δυσκολιών και να βελτιωθούν οι συνθήκες υλοποίησης διαφοροποιημένων προγραμμάτων στο μάθημα της μουσικής.

Τα ερευνητικά ερωτήματα ήταν τα ακόλουθα:

1. Ποιες είναι οι απόψεις και οι εμπειρίες των εκπαιδευτικών μουσικής αγωγής από την υλοποίηση διαφοροποιημένων προγραμμάτων στις τάξεις τους;
2. Ποιες είναι οι απόψεις των εκπαιδευτικών μουσικής για τους παράγοντες που επηρεάζουν τους τρόπους εφαρμογής διαφοροποιημένων προγραμμάτων στο μάθημα της μουσικής αγωγής;
3. Ποιες είναι οι προτάσεις των εκπαιδευτικών για τη βελτίωση των διαφοροποιημένων προγραμμάτων κατά τη διδασκαλία του μαθήματος της μουσικής;

ΜΕΘΟΔΟΛΟΓΙΑ

Συμμετέχοντες

Η έρευνα διήρκησε περίπου οχτώ μήνες (από τον Οκτώβριο 2015 έως και Ιούνιο 2016) και το δείγμα επιλέχθηκε από τους εν ενεργεία εκπαιδευτικούς μουσικής που ανήκαν στην Α΄ Διεύθυνση Πρωτοβάθμιας Εκπαίδευσης Αθήνας. Η συγκεκριμένη Διεύθυνση καλύπτει γεωγραφικά ένα ευρύ και ποικιλόμορφο κοινωνικο-οικονομικό πληθυσμό μαθητών. Οι συμμετέχοντες επιλέχθηκαν με την τεχνική της σκόπιμης δειγματοληψίας (Κυριαζή, 2011) προκειμένου να διασφαλιστεί η κατάλληλη εκπροσώπηση των περιοχών της εν λόγω Διεύθυνσης ως προς το κοινωνικο-οικονομικό επίπεδο των μαθητών και ώστε να ισχύει η ποσοστιαία εκπροσώπηση των δύο φύλων. Αφού η έρευνα εγκρίθηκε από την επιτροπή ηθικής και δεοντολογίας του κέντρου ερευνών του Ευρωπαϊκού Πανεπιστημίου Κύπρου, κλήθηκαν να συμμετάσχουν σε συνεντεύξεις έξι εν ενεργεία εκπαιδευτικοί μουσικής αγωγής, οι οποίοι ανταποκρίθηκαν θετικά. Κριτήρια για την επιλογή τους αποτέλεσαν:

α) η υπηρέτηση σε δημοτικό σχολείο της Α΄ Διεύθυνσης Αθήνας κατά την περίοδο που διεξαγόταν η έρευνα,
β) η κατοχή οργανικής θέσης στο σχολείο αυτό,
γ) η διδασκαλία σε τμήματα με μαθητές μεικτών ικανοτήτων (μαθητές τυπικής ανάπτυξης και μαθητές με ειδικές εκπαιδευτικές ανάγκες), και
δ) η πολυετής διδακτική πείρα (πάνω από δεκαετία) στη δημόσια πρωτοβάθμια εκπαίδευση.

Εργαλείο συλλογής δεδομένων

Για την εκπόνηση της έρευνας επιλέχτηκε η ποιοτική μεθοδολογία φαινομενολογικής προσέγγισης, καθώς προσδιορίστηκε ως η πιο κατάλληλη για να περιγράψει τις εμπειρίες και απόψεις των εκπαιδευτικών μουσικής. Η φαινομενολογική προσέγγιση επιτρέπει την περιγραφή, ανάλυση, ερμηνεία και κατανόηση κοινωνικών φαινομένων μέσα στο πλαίσιο στο οποίο εκτυλίσσονται, όπως είναι η τάξη και το σχολικό περιβάλλον (Creswell, 2003). Επίσης, η φαινομενολογική προσέγγιση στην ποιοτική μεθοδολογία χρησιμοποιείται για να περιγράψουμε φαινόμενα για τα οποία οι γνώσεις μας είναι περιορισμένες δίνοντας έμφαση στον τρόπο με τον οποίο βιώνεται και γίνεται

κατανοητό ένα φαινόμενο, καθώς και να αποκτήσουμε νέες προοπτικές για στοιχεία που δεν είναι εφικτό να ποσοτικοποιηθούν (Strauss & Corbin, 1990).

Συγκεκριμένα η χρήση ημι-δομημένων συνεντεύξεων για τη συλλογή των δεδομένων παρέχει τη δυνατότητα για τη διερεύνηση των απόψεων των συμμετεχόντων μέσα σε ένα ερμηνευτικό πλαίσιο (Seidman, 2006), και για την καταγραφή των προσωπικών εμπειριών του κάθε εκπαιδευτικού (Cohen, Manion & Morrison, 2007· Τσιώλης, 2014). Ο σκοπός της συνέντευξης αυτού του τύπου είναι η συλλογή όσο το δυνατό περισσότερων πληροφοριών για τις εμπειρίες, τις στάσεις, τα συναισθήματα, τα κίνητρα και τις σκέψεις των ερωτώμενων (Robson, 2007). Επιπλέον, η ποιοτική προσέγγιση του θέματος ενθαρρύνει την αναζήτηση νέων κατευθύνσεων και προοπτικών για το θέμα (Merriam, 2002). Στη συγκεκριμένη έρευνα, αναζητήθηκαν νέες κατευθύνσεις και προοπτικές για την εφαρμογή και αξιοποίηση των διαφοροποιημένων προγραμμάτων στο μάθημα της μουσικής.

Για τη διαδικασία των συνεντεύξεων διαμορφώθηκε ένας οδηγός συνέντευξης που αποτελούνταν από πέντε μέρη: α) Δημογραφικά στοιχεία, β) Εμπειρία των εκπαιδευτικών σε θέματα διαφοροποιημένης διδασκαλίας, γ) Παράγοντες που επηρεάζουν τη διαφοροποίηση της διδασκαλίας, δ) Δυσκολίες στην εφαρμογή διαφοροποιημένης διδασκαλίας και ε) Προτάσεις εκπαιδευτικών για βελτίωση στην εφαρμογή διαφοροποιημένης διδασκαλίας σύμφωνα με τα ερευνητικά ερωτήματα. Οι συνεντεύξεις συμπεριλάμβαναν ερωτήσεις ανοιχτού τύπου προκειμένου οι συμμετέχοντες να δώσουν τις απαντήσεις τους χωρίς προκαθορισμούς και να έχουν τη δυνατότητα να αναπτύξουν τις στάσεις και αντιλήψεις τους σε σχέση με τα βασικά ερωτήματα της έρευνας. Κάθε συνέντευξη διήρκησε περίπου 30′−40′ σε τόπο και χρόνο που επέλεξε ο κάθε εκπαιδευτικός, ούτως ώστε να νιώθει άνετα και να μην αισθάνεται την πίεση του χρόνου που, ενδεχομένως, θα επηρέαζε τις απαντήσεις, ποσοτικά και ποιοτικά.

Πριν από κάθε συνέντευξη οι συμμετέχοντες ενημερώθηκαν για τους στόχους της έρευνας, πού αποσκοπεί, ποιες διαδικασίες πρόκειται να ακολουθηθούν και ποια τα πιθανά οφέλη αλλά και οι κίνδυνοι από τη συμμετοχή τους στην έρευνα. Επίσης, επιβεβαιώθηκε η ελεύθερη και εθελοντική συμμετοχή τους και η διασφάλιση της ανωνυμίας. Οι συμμετέχοντες έδωσαν συγκατάθεση για την ηχογράφηση των συνεντεύξεων (σύμφωνα με την έγκριση από την επιτροπή ηθικής και δεοντολογίας) για την καλύτερη ανάλυση των πληροφοριών. Τα ερωτήματα της συνέντευξης παρατίθενται στο Παράρτημα.

Ανάλυση δεδομένων

Η θεματική ανάλυση επιτρέπει την απόδοση νοήματος στα ποιοτικά δεδομένα που έχουν συγκεντρωθεί με στόχο την απάντηση των ερευνητικών ερωτημάτων (Ιωσηφίδης, 2008). Για την ανάλυση των δεδομένων ακολουθήθηκαν τα βήματα της θεματικής ανάλυσης, σύμφωνα με τους Braun και Clarke (2006).

Αρχικά, τα ηχητικά αρχεία των συνεντεύξεων απομαγνητοφωνήθηκαν ολόκληρα. Η πρώτη συγγραφέας συγκέντρωσε τα δεδομένα, τα οργάνωσε σε αρχεία ηλεκτρονικής μορφής και απέδωσε ένα μοναδικό νούμερο σε κάθε αρχείο, το οποίο αντιστοιχούσε στον μοναδικό αριθμό που αποδόθηκε σε κάθε συμμετέχοντα. Στη συνέχεια, η ίδια πραγματοποίησε πολλαπλή ανάγνωση του περιεχομένου των συνεντεύξεων. Κατά τη διάρκεια της φάσης αυτής, προχώρησε σε

κωδικοποίηση του κειμένου. Στο επόμενο στάδιο, πραγματοποιήθηκε κατηγοριοποίηση όμοιων κωδικών, σύμφωνα με τις βασικές ιδέες που προέκυψαν από τις απαντήσεις των συμμετεχόντων. Από την ανάλυση της έρευνας προέκυψαν 15 κύριες κατηγορίες που έπειτα ομαδοποιήθηκαν σε θεματικές ενότητες. Σε κάθε θεματική ενότητα δόθηκε μια ονομασία, ανάλογα με το περιεχόμενο των απαντήσεων. Επιπλέον, σε κάθε θεματική ενότητα οι απαντήσεις των συμμετεχόντων ταξινομήθηκαν σε τρεις κατηγορίες: «αρνητική στάση», «θετική στάση» και «ουδέτερη στάση», προκειμένου να διερευνηθούν περαιτέρω οι απόψεις των συμμετεχόντων αναφορικά με τη διαφοροποιημένη διδασκαλία και να επιτευχθεί σύνδεση και σύνθεση των συγκεκριμένων αποτελεσμάτων με την ευρύτερη βιβλιογραφία στον χώρο της ειδικής αγωγής. Με την ολοκλήρωση της διαδικασίας προέκυψαν τρεις θεματικές ενότητες οι οποίες παρατίθενται αναλυτικά στα αποτελέσματα της έρευνας.

Διαφύλαξη αξιοπιστίας

Στην ποιοτική έρευνα οι έννοιες της αξιοπιστίας και της εγκυρότητας συνδέονται με τις έννοιες της συνέπειας και της φερεγγυότητας των αποτελεσμάτων (Bassey, 1999· Lather, 1997). Στη συγκεκριμένη έρευνα, η αξιοπιστία των αποτελεσμάτων διασφαλίστηκε με δύο τρόπους: α) μέσω της σύγκρισης και της επαλήθευσής τους με έναν δεύτερο, κριτικό αναγνώστη και β) μέσα από την επαλήθευση με τους ίδιους τους συμμετέχοντες (member check).

Ο δεύτερος αναγνώστης επιλέχθηκε με κριτήριο την εμπειρία του σε ερευνητικό έργο, τις σχετικές ανώτατες σπουδές, καθώς και την πολυετή διδακτική του πείρα στην ειδική αγωγή και τη μουσική εκπαίδευση. Στο στάδιο της ανάλυσης, ο κριτικός αναγνώστης ακολούθησε την ίδια διαδικασία παρατεταμένης ενασχόλησης με το περιεχόμενο των συνεντεύξεων, της κωδικοποίησης και της ομαδοποίησης των κωδικοποιημένων αποτελεσμάτων σε θεματικές ενότητες. Έπειτα, ο κριτικός αναγνώστης με την κύρια ερευνήτρια αντιπαρέβαλαν, συζήτησαν και επαλήθευσαν από κοινού τις θεματικές ενότητες στις οποίες είχαν καταλήξει. Από τις συζητήσεις αυτές προέκυψαν τρεις θεματικές ενότητες που αποτελούν συμπυκνωμένες και αντιπροσωπευτικές περιγραφές των αποκρίσεων των συμμετεχόντων.

Τέλος, αφού ολοκληρώθηκε η καταγραφή των αποτελεσμάτων, οι συμμετέχοντες κλήθηκαν από την κύρια ερευνήτρια να διαβάσουν τα αποτελέσματα, και επιβεβαίωσαν την ορθότητα και εγκυρότητα των απόψεων και ερμηνειών που παρουσιάζονται στα αποτελέσματα της έρευνας.

ΑΠΟΤΕΛΕΣΜΑΤΑ

Το τελικό δείγμα αποτελούνταν από έξι συμμετέχοντες και των δύο φύλων, με το 85% των εκπαιδευτικών να είναι γυναίκες και το 15% άντρες. Το ηλικιακό εύρος των συμμετεχόντων ήταν από 43 έως 51 ετών και η διδακτική τους προϋπηρεσία κυμαινόταν από 13 έως 24 χρόνια. Όλοι οι συμμετέχοντες δούλευαν σε σχολεία γενικής παιδείας που συμπεριλάμβαναν και μαθητές με ειδικές εκπαιδευτικές ανάγκες. Από τους έξι συμμετέχοντες κανένας δεν δήλωσε πως έχει εξιδεικευμένες γνώσεις ειδικής αγωγής, ενώ η πλειοψηφία ανέφερε πως δεν είχε παρακολουθήσει σεμινάρια και επιπλέον επιμόρφωση. Τέλος, κανένας από τους συμμετέχοντες δεν ήταν κάτοχος

μεταπτυχιακού τίτλου σπουδών στην ειδική αγωγή. Ο Πίνακας 1 παρουσιάζει συνοπτικά τα δημογραφικά στοιχεία των συμμετεχόντων.

Κατάρτιση εκπαιδευτικών και η διαφοροποιημένη διδασκαλία στην πράξη

Ένα από τα κύρια σημεία που προέκυψε κατά τη διάρκεια των συνεντεύξεων με τους συμμετέχοντες ήταν τα επίπεδα προετοιμασίας και γνώσεων που διέθεταν οι εκπαιδευτικοί μουσικής αγωγής προκειμένου να εργαστούν με μαθητές που εμφανίζουν ειδικές μαθησιακές δυσκολίες και άλλες εκπαιδευτικές ανάγκες. Οι συμμετέχοντες δήλωσαν πως η εκπαίδευσή τους σε προπτυχιακό και μεταπτυχιακό επίπεδο, πριν ακόμη ξεκινήσουν τη διδασκαλία, δεν πρόσφερε γνώσεις και δεξιότητες ώστε να νιώσουν επαρκείς για τη διδασκαλία μαθητών με ειδικές εκπαιδευτικές ανάγκες και τη διαφοροποίηση της διδακτικής πράξης. Σε σχετική ερώτηση η Κ. ανέφερε: «Δυστυχώς, δεν μου δόθηκε η δυνατότητα να προετοιμαστώ κατά τη διάρκεια των σπουδών μου...», ενώ η Λ. παρατήρησε ότι : «Δεν είχα την τύχη να παρακολουθήσω όσο ήμουν στο πανεπιστήμιο...». Η Μ2. δήλωσε ότι νιώθει ανεπαρκής γιατί «δεν έλαβε ποτέ την κατάλληλη εκπαίδευση στο πανεπιστήμιο» και για αυτόν τον λόγο, αναζητά «βοήθεια από τον εκπαιδευτικό του τμήματος ένταξης και στο διαδίκτυο για πληροφορίες για τις περιπτώσεις μαθητών που υπάρχουν στην τάξη». Μόνο η Ε. ανέφερε πως πρόσφερε εθελοντική εργασία σε παιδιά με νοητική στέρηση και κινητικά προβλήματα, ως φοιτήτρια. Όπως επεσήμανε, η συγκεκριμένη πρακτική άσκηση ήταν προσωπική επιλογή και δεν υπήρχε μάθημα που να προετοιμάζει τους φοιτητές για την αντιμετώπιση μαθητών με ειδικές εκπαιδευτικές ανάγκες.

Συμμετέχοντες	n	%
Φύλο		
Άντρες	1	15
Γυναίκες	5	85
Ηλικία		
40 - 45	3	50
45 - 50	1	15
50 - 55	2	35
Ανώτερος τίτλος σπουδών		
Πτυχίο Πανεπιστημίου	6	100
Διδακτορικός Τίτλος Σπουδών	1	15
Μεταπτυχιακός τίτλος στην ειδική αγωγή	0	0
Έτη προϋπηρεσίας στην πρωτοβάθμια εκπαίδευση		
10 - 15	1	15
15 - 20	2	35
20 και άνω	3	50

Πίνακας 1: Δημογραφικά στοιχεία συμμετεχόντων (n=6)

Ομοίως, κατά τη διάρκεια της επαγγελματικής τους πορείας, οι συμμετέχοντες δήλωσαν πως είχαν λίγες ευκαιρίες για επιμόρφωση σε θέματα διαφοροποίησης και ειδικών εκπαιδευτικών αναγκών. Όπως ανέφεραν, τα σεμινάρια που διοργανώνονται δεν επαρκούν για να καλύψουν τις ανάγκες των εκπαιδευτικών μουσικής. Επιπρόσθετα, οι επιμορφώσεις σε θέματα ειδικών εκπαιδευτικών αναγκών δεν είναι σχεδόν ποτέ αμιγώς μουσικές, αφού συνήθως αναφέρονται σε γενικές πρακτικές αντιμετώπισης μαθητών και όχι σε εξειδικευμένες τεχνικές που αφορούν στο μάθημα της μουσικής αγωγής. Συγκεκριμένα, η Κ. ανέφερε ότι:

> Στα σεμινάρια οι πληροφορίες είναι γενικές και αφορούν στους τρόπους ενίσχυσης των μαθητών με ειδικές εκπαιδευτικές ανάγκες, κατά τη διδακτική διαδικασία. Δεν εστιάζουν στη μουσική διδασκαλία. (Κ)

Κατά συνέπεια, οι εκπαιδευτικοί μουσικής δεν έχουν την ευκαιρία να επωφεληθούν από εφαρμογές και πρακτικές της διαφοροποιημένης εκπαίδευσης, με έμφαση στην οργάνωση και τον βιωματικό χαρακτήρα του μαθήματος της μουσικής, στο σύγχρονο σχολείο.

Η έλλειψη ενημέρωσης και επιμόρφωσης σε θέματα διαφοροποιημένης διδασκαλίας φαίνεται να οδηγεί σε ελλιπή κατανόηση και εφαρμογή της, στην εκπαιδευτική διαδικασία. Από τις περιγραφές και τα παραδείγματα που μοιράστηκαν οι συμμετέχοντες διαφαίνεται ότι ταυτίζουν σε μεγάλο βαθμό τη «διαφοροποίηση» με την απλούστευση των δραστηριοτήτων του μαθήματος. Σε ερώτηση σχετικά με το αν και πώς διαφοροποιούν τη διδακτική πράξη, οι συμμετέχοντες δήλωσαν ότι συνήθως, προσπαθούν να απλοποιούν τη διδασκαλία του μαθήματος, σύμφωνα με τη διδακτική εμπειρία που έχουν, ώστε να μπορούν να συμμετέχουν όλοι οι μαθητές. Για παράδειγμα, η Μ2 ανέφερε:

> Συνήθως, για να ανταποκριθεί ο μαθητής με ειδικές εκπαιδευτικές ανάγκες, κάνω πράγματα όπως: απλουστευμένες ασκήσεις μουσικής ανάγνωσης, εύκολο ρυθμικό παίξιμο με μουσικά όργανα, εύκολες ασκήσεις μουσικοκινητικής, παιχνίδια με πλαστελίνη, κύβους, όργανα Orff.

Η Κ. δήλωσε ότι:

> Δεν προγραμματίζω κάτι από πριν. Αυτοσχεδιάζω εκείνη τη στιγμή, ανάλογα με την περίπτωση.

Ο Μ1. επεσήμανε ότι:

> Αισθάνομαι ότι δρω με βάση αυτά που ξέρω ή με βάση αυτά που φαντάζομαι ότι ξέρω πολλές φορές.

Παρόμοια, η Ε. ανέφερε ότι η εμπειρία τη βοηθάει ώστε:

> ...αν δω ότι ο μαθητής δεν μπορεί να συμμετέχει σε κάποια δραστηριότητα που γίνεται, κάτι θα σκεφτώ να κάνω».

Σαφώς, προσωπική ευθύνη κάθε εκπαιδευτικού είναι να αφιερώνει χρόνο για τον κατάλληλο προγραμματισμό των δραστηριοτήτων και του προγράμματος διδασκαλίας για τους μαθητές του. Πιθανόν οι συμμετέχοντες εκπαιδευτικοί να βασίζονται στην πολύχρονη διδακτική εμπειρία τους, και οι υπάρχουσες γνώσεις που έχουν να επαρκούν για τη διδασκαλία σε μαθητές τυπικής ανάπτυξης. Διαφαίνεται από τις απαντήσεις πως ακολουθούν την ίδια τακτική για τη διαφοροποιημένη διδασκαλία παρόλο που διαπιστώνουν ελλείψεις και δυσκολίες στη διαδικασία. Από τους έξι συμμετέχοντες μόνο η Λ. δήλωσε ότι προσπάθησε προγραμματισμένα και για σειρά μαθημάτων να «τροποποιήσει» τη διδακτική διαδικασία για να διευκολύνει μαθητή που βρίσκεται στο φάσμα του αυτισμού.

Παρά την ελλιπή κατανόηση της διαφοροποιημένης διδασκαλίας, οι συμμετέχοντες βρίσκουν θετική την εφαρμογή της στο διδακτικό πλαίσιο, επειδή βοηθά τους μαθητές σε επίπεδο γνώσεων και στην κοινωνικοποίησή τους και επειδή συμβάλλει στη συμμετοχή όλων των μαθητών με βάση τα ενδιαφέροντά τους. Μάλιστα, δήλωσαν πως νιώθουν πιο ενεργοί και αισθάνονται χαρά και ικανοποίηση όταν διαπιστώσουν ότι ο μαθητής ανταποκρίθηκε στη διαφοροποιημένη διδασκαλία και κατέκτησε τους διδακτικούς στόχους που έθεσε ο εκπαιδευτικός κατά τον σχεδιασμό της. Ο Μ1 σχολίασε ότι:

> Όταν καταφέρεις, ένα παιδί με κινητικά προβλήματα, με την κατάλληλη προσαρμογή της δραστηριότητας, να το βάλεις στο παιχνίδι, θα το δεις στο χαμόγελό του, ότι καταφέρνει να συμμετέχει…

Φαίνεται πως οι εκπαιδευτικοί τροποποιούν τις μουσικές δραστηριότητες με βάση τη διδακτική εμπειρία τους κατά τη διάρκεια του μαθήματος χωρίς να έχουν οργανώσει εκ των προτέρων συγκεκριμένο σχεδιασμό του μαθήματος για τους μαθητές με ειδικές εκπαιδευτικές ανάγκες. Ωστόσο, η εμπειρία δεν αρκεί για τη σωστή αντιμετώπιση και εφαρμογή διαφοροποιημένης διδακτικής προσέγγισης, αφού ο ορισμός της διαφοροποίησης δεν ταυτίζεται μόνο με την απλοποίηση ή την τροποποίηση των δραστηριοτήτων (Παντελιάδου, 2013). Έτσι, παρά τη θετική διάθεση να διαφοροποιήσουν τη διδασκαλία τους προκειμένου να δουλέψουν αποτελεσματικά με όλους τους μαθητές στις τάξεις τους, η έλλειψη σε επίπεδο σπουδών, επιμόρφωσης και συνεχιζόμενης εκπαίδευσης φαίνεται πως οδηγούν σε μερική, μόνο, εφαρμογή πρακτικών διαφοροποιημένης διδασκαλίας στις τάξεις τους.

Δυσκολίες στην εφαρμογή διαφοροποιημένης διδασκαλίας

Οι συμμετέχοντες αναφέρθηκαν στις δυσκολίες που αντιμετωπίζουν κατά τον σχεδιασμό και την εφαρμογή διαφοροποιημένων προγραμμάτων σε σχέση με τη διδασκαλία του μαθήματος της μουσικής. Έτσι, δύο εκπαιδευτικοί παρατήρησαν ότι η έλλειψη αίθουσας μουσικής και κατάλληλου εποπτικού υλικού στο σχολείο αποτελεί εμπόδιο για την εφαρμογή διαφοροποιημένων προγραμμάτων. Η Ε. τόνισε ότι «όταν δεν υπάρχει αίθουσα μουσικής, δεν μπορείς να εφαρμόσεις τίποτα εναλλακτικό». Παρόμοια, ο Μ1. πρόσθεσε ότι:

> Όταν κάνεις μάθημα, χωρίς ειδικά διαμορφωμένη αίθουσα, δεν μπορείς να
> κάνεις μουσικοκινητική, δεν μπορείς να χρησιμοποιήσεις νέες τεχνολογίες,
> όταν δεν έχεις wifi, έστω για να φέρεις το δικό σου laptop. Όλα αυτά θα
> βοηθούσαν την τάξη γενικά, θα βοηθούσαν πάρα πολύ και στις ειδικές
> περιπτώσεις μαθητών και στην εφαρμογή διαφοροποιημένων προγραμμάτων.

Παρόλο που πρόκειται για γενικό ζήτημα διδασκαλίας του μαθήματος της μουσικής, το πρόβλημα γίνεται πιο έντονο όταν υπάρχουν στην τάξη μαθητές με συγκεκριμένες δυσκολίες όπως η ευαισθησία στον ήχο, μειωμένη κινητικότητα για συμμετοχή σε μουσικά παιχνίδια και μειωμένη συγκέντρωση προσοχής. Οι συμμετέχοντες παρατήρησαν πως τέτοια χαρακτηριστικά δυσχεραίνουν τη συμμετοχή των μαθητών στις μουσικές εμπειρίες.

Άλλες δυσκολίες σχετίζονται με τη δομή των αναλυτικών προγραμμάτων και τη θέση του μαθήματος της μουσικής στο εβδομαδιαίο σχολικό πρόγραμμα. Οι μισοί από τους συμμετέχοντες εκπαιδευτικούς παρουσίασαν ως ανασταλτικό παράγοντα το γεγονός ότι το μάθημα της μουσικής στην πρωτοβάθμια εκπαίδευση είναι μονόωρο, καθώς και την απουσία εκπαιδευτικού «παράλληλης στήριξης» κατά τη διδασκαλία του μαθήματος. Επιπρόσθετα, η κάλυψη διαφορετικών σχολείων μέσα στην εβδομάδα και ο μεγάλος αριθμός μαθητών που έχουν συνολικά προσθέτουν επιπλέον δυσκολίες. Έτσι, ένας εκπαιδευτικός παρατήρησε πως η αλλαγή σχολείου και ο αριθμός μαθητών που έχει κάθε χρονιά (περίπου 300-400 παιδιά) οδηγεί σε υπερφόρτωση προγράμματος, σε επιπλέον προβλήματα στην οργάνωση των προγραμμάτων και καθυστερήσεις στην υλοποίησή τους. Συγκεκριμένα, η Α. ανέφερε ότι:

> Οι λίγες ώρες του μαθήματος, σε συνδυασμό με τον μεγάλο αριθμό των
> μαθητών που συναντά ένας εκπαιδευτικός μουσικής κάθε εβδομάδα, δεν
> επιτρέπει την ανάπτυξη ιδιαίτερων σχέσεων με τους μαθητές. (Α)

Οι δυσκολίες επεκτείνονται σε θέματα συνεργασίας με τις οικογένειες των μαθητών και με συναδέλφους άλλων ειδικοτήτων στο σχολείο, καθώς ομόφωνα οι συμμετέχοντες τόνισαν ότι υπάρχει έλλειψη ενημέρωσης και επικοινωνίας από τους δασκάλους των τμημάτων αναφορικά με ειδικές περιπτώσεις στην κάθε τάξη. Μόνο δύο εκπαιδευτικοί δήλωσαν ότι είχαν κάποια ενημέρωση, αλλά όταν επρόκειτο για εξαιρετικά δύσκολες περιπτώσεις μαθητών. Συγκεκριμένα, «…μόνο για τις πολύ δύσκολες περιπτώσεις και πολλές φορές ούτε για αυτές» (Λ).

Επιπλέον, οι εκπαιδευτικοί ανέφεραν ότι δεν παρατηρείται ένα ικανοποιητικό επίπεδο συνεργασίας με τη διεύθυνση του σχολείου, καθώς και με το οικογενειακό περιβάλλον του μαθητή. Αντίθετα, η συνεργασία με τους εκπαιδευτικούς ειδικής αγωγής κρίνεται από όλους τους συμμετέχοντες απαραίτητη, αφού ο συνάδελφος που διαθέτει εξειδικευμένες γνώσεις μπορεί να βοηθήσει, σε σημαντικό βαθμό, τη διδακτική πράξη. Ωστόσο, ένας εκπαιδευτικός δήλωσε ότι έχει και αρνητικές εμπειρίες από τη συνεργασία με συνάδελφο της ειδικής αγωγής και ότι «όλα εξαρτώνται από το χαρακτήρα του συναδέλφου και κατά πόσο είναι ανοιχτό μυαλό ή όχι. Μου έχει τύχει να είναι και αδιάφοροι» (Ε).

Δύο από τους συμμετέχοντες εκπαιδευτικούς αναφέρθηκαν στον επιπλέον χρόνο προετοιμασίας ο οποίος απαιτείται για τον σχεδιασμό και την οργάνωση διαφοροποιημένου

προγράμματος. Δεδομένου πως η κατάρτισή τους στο θέμα είναι ελλιπής, προκύπτουν δυσκολίες κατά την οργάνωση και εφαρμογή κατάλληλων μουσικών δραστηριοτήτων (παρά την πολυετή εμπειρία τους στην εκπαίδευση). Κάποιοι από τους συμμετέχοντες σημείωσαν ότι αν υπήρχε έτοιμο υλικό και προτεινόμενες δραστηριότητες από το υπουργείο παιδείας, που θα μπορούσαν να εφαρμοστούν άμεσα, ή ειδικές αναφορές στο αναλυτικό πρόγραμμα, η υλοποίηση διαφοροποιημένων προγραμμάτων θα ήταν πιο εύκολη. Ακόμη, οι εκπαιδευτικοί στην πλειοψηφία τους τοποθετήθηκαν αρνητικά σχετικά με τη στάση του υπουργείου παιδείας. Όπως ανέφεραν, δεν παρέχεται βοήθεια στον εκπαιδευτικό μουσικής για την εφαρμογή διαφοροποιημένης διδασκαλίας ούτε σε υλικοτεχνικό ούτε σε ψυχοσυναισθηματικό επίπεδο.

Όσον αφορά τις διαφορετικές μαθησιακές ανάγκες και δυνατότητες των μαθητών σε κάθε τάξη, οι συμμετέχοντες υποστήριξαν ότι οι περιπτώσεις μαθητών με συναισθηματικές δυσλειτουργίες είναι πιο δύσκολες στην αντιμετώπισή τους από τις περιπτώσεις μαθητών με γνωστικές δυσλειτουργίες. Με γνώμονα κυρίως τη διδακτική εμπειρία και τις περιπτώσεις μαθητών με ειδικές εκπαιδευτικές ανάγκες που έχουν κληθεί να αντιμετωπίσουν, οι εκπαιδευτικοί παραδέχθηκαν ότι οι περιπτώσεις μαθητών με συναισθηματικές δυσλειτουργίες τούς προκαλούν μεγαλύτερο άγχος και, τελικά, οι ίδιοι διαφοροποιούν πιο δύσκολα τη διδασκαλία τους. Συγκεκριμένα, αναφέρθηκε ότι ειδικά στο μάθημα της μουσικής αγωγής:

> …τη γνωστική δυσλειτουργία του παιδιού την προσεγγίζεις με απλό τρόπο. Με το ρυθμό, χτυπάμε παλαμάκια, θα σηκωθούμε να χορέψουμε… Μπορείς σίγουρα να κερδίσεις την προσοχή του παιδιού… υπάρχουν διάφοροι τρόποι. Ενώ, με έναν μαθητή με συναισθηματικά προβλήματα, αποξενωμένο από την υπόλοιπη τάξη ή όχι εκδηλωτικό, μπορεί να συναντήσεις «τοίχο». Να μην μπορείς να προχωρήσεις παρακάτω, να μην μπορείς να τον προσεγγίσεις, να μην καταφέρνεις να τον «αγγίξεις» με ό,τι κάνεις… (Μ1)

Προτάσεις για τη βελτίωση στην εφαρμογή διαφοροποιημένων προγραμμάτων

Στις προτάσεις σχετικά με τη βελτίωση στην εφαρμογή της διαφοροποίησης, οι εκπαιδευτικοί ζήτησαν ομόφωνα «επιμόρφωση». Θεωρούν ότι χωρίς τη σχετική επιμόρφωση δεν μπορούν να διαφοροποιήσουν σωστά τη διδασκαλία τους. Η Λ. επεσήμανε ότι «οι εκπαιδευτικοί μουσικής έχουμε ανάγκη από σεμινάρια στοχευμένα, εργαστήρια βιωματικά, με άμεσα εφαρμόσιμες πρακτικές». Παρόμοια, η Α. πρόσθεσε ότι «η ενημέρωση θα μας βοηθούσε, έστω και στο πλαίσιο των τυπικών συναντήσεων με τη σύμβουλο μουσικής». Μάλιστα, υπήρξε η πρόταση η προετοιμασία των εκπαιδευτικών, σε προπτυχιακό επίπεδο, να περιλαμβάνει υποχρεωτική πρακτική εξάσκηση σε ειδικό σχολείο.

Επιπρόσθετα, οι εκπαιδευτικοί πρότειναν να υπάρχει εκπαιδευτικός «παράλληλης στήριξης» και στο μάθημα της μουσικής αγωγής, τουλάχιστον στις πιο δύσκολες περιπτώσεις μαθητών. Δηλαδή, όπως ανέφεραν, σε μαθητές με αυτισμό, επιθετική συμπεριφορά και ΔΕΠΥ. Συγκεκριμένα, παρατήρησαν ότι η συνεχής παρουσία ενός συναδέλφου ειδικής αγωγής είναι ουσιαστική και θα ήταν εξαιρετικά χρήσιμη στην εφαρμογή διαφοροποιημένης διδασκαλίας.

Προκειμένου να αξιοποιηθούν οι δυνατότητες που προσφέρει η μουσική σε σχέση με τα παιδιά με ειδικές εκπαιδευτικές ανάγκες, οι συμμετέχοντες δήλωσαν πως είναι σημαντική η αύξηση των ωρών του μαθήματος στο εβδομαδιαίο ωρολόγιο πρόγραμμα. Η Α. παρατήρησε ότι «τα παιδιά με ειδικές εκπαιδευτικές ανάγκες αγαπούν τη μουσική, νιώθουν άνετα μέσα στο μάθημα και γι' αυτό μπορεί να βοηθηθούν πολύ από το μάθημά μας. Είναι απαραίτητη η συχνότερη επαφή». Παρόμοια, ο Μ1. πρόσθεσε, ότι

> η μουσική θα μπορούσε να βοηθήσει τον μαθητή ακόμα και να βελτιώσει την επίδοσή του στα υπόλοιπα μαθήματα. Να βελτιώσει τον ψυχισμό του, τη συναισθηματική του κατάσταση και την κοινωνικοποίησή του. Αλλά σίγουρα, χρειάζεται μια συχνότερη επαφή.

Τέλος, οι εκπαιδευτικοί παρατήρησαν ότι για να επιτευχθεί βελτίωση στη διδασκαλία μαθητών με ειδικές εκπαιδευτικές ανάγκες μέσα από το μάθημα της μουσικής, υπάρχει ανάγκη για ευαισθητοποίηση όχι μόνο των συναδέλφων εκπαιδευτικών, αλλά γενικά της κοινωνίας, σε θέματα αναπηρίας. Έτσι, σύμφωνα με τη Λ., πρέπει να «καλλιεργηθεί κλίμα συνεργασίας, αλλά και σεβασμού και αγάπης για τους συγκεκριμένους μαθητές». Η Ε. πρόσθεσε ότι «οι εκπαιδευτικοί άλλων ειδικοτήτων θα έπρεπε να έχουν μεγαλύτερη ευαισθησία για το μάθημά μας και να αναγνωρίζουν την αξία του γι' αυτά τα παιδιά». Μέσα από την ευρύτερη κοινωνική αποδοχή, η εκπαίδευση των μαθητών με ειδικές εκπαιδευτικές ανάγκες μπορεί να περάσει σε άλλο επίπεδο και οι ιδιαίτερες ανάγκες των μαθητών να καλύπτονται πιο ουσιαστικά μέσα στο διδακτικό πλαίσιο.

ΕΠΙΛΟΓΟΣ - ΣΥΖΗΤΗΣΗ

Τα αποτελέσματα της παρούσας έρευνας καταδεικνύουν αφενός τις θετικές απόψεις των εκπαιδευτικών για τη διαφοροποιημένη διδασκαλία και αφετέρου τις πιθανές παρανοήσεις που δημιουργούνται ως προς τη διδακτική διαδικασία και τις δυσκολίες που αντιμετωπίζουν οι εκπαιδευτικοί κατά τη διαδικασία εφαρμογής των προγραμμάτων διαφοροποιημένης διδασκαλίας στις τάξεις τους. Στη συνέχεια, παρουσιάζονται οι βασικοί άξονες που προέκυψαν από τα αποτελέσματα της έρευνας και σχετίζονται με τη σύγχρονη, σχετική βιβλιογραφία για την εκπαίδευση και την κατάρτιση των εκπαιδευτικών μουσικής, το νομοθετικό πλαίσιο για τη διδασκαλία της μουσικής στην ενιαία εκπαίδευση. Παρατίθενται οι περιορισμοί της συγκεκριμένης έρευνας καθώς και οι προτάσεις για την υλοποίηση διαφοροποιημένων προγραμμάτων στο μάθημα της μουσικής, ως ένα σημαντικό βήμα για την εκπαίδευση των μαθητών με ειδικές εκπαιδευτικές ανάγκες.

Εκπαίδευση και επιμόρφωση

Στην παρούσα έρευνα οι συμμετέχοντες εκπαιδευτικοί επεσήμαναν ότι νιώθουν υπεύθυνοι για τη διδασκαλία όλων των μαθητών στις τάξεις τους, έδειξαν πως κατανοούν τις διαφορετικές ανάγκες των μαθητών και εξέφρασαν ενδιαφέρον και επιθυμία για την απόκτηση γνώσεων που θα τους βοηθήσουν να ανταπεξέλθουν στις ιδιαίτερες περιπτώσεις μαθητών που αντιμετωπίζουν

καθημερινά στο σύγχρονο ελληνικό σχολείο. Σχετική βιβλιογραφία δείχνει πως οι εκπαιδευτικοί μουσικής δηλώνουν υπεύθυνοι για τους μαθητές με ειδικές εκπαιδευτικές ανάγκες που υπάρχουν στην τάξη (Hahn, 2010) και τονίζουν ότι θέλουν και προσπαθούν να τους βοηθήσουν (Blair, 2009, Hammel & Gerrity, 2012· VanWeelden & Whipple, 2014).

Όμως, οι συμμετέχοντες εκπαιδευτικοί φαίνεται πως δεν γνωρίζουν όλα τα επίπεδα της διαφοροποιημένης διδασκαλίας, δεν έχουν μια ολοκληρωμένη εικόνα για τις τεχνικές διαφοροποίησης και τελικά την ταυτίζουν με την απλοποίηση της διδασκαλίας. Οι ίδιοι επεσήμαναν πως δεν διαθέτουν επιστημονικό υπόβαθρο για τη διδασκαλία μαθητών με ειδικές εκπαιδευτικές ανάγκες και δήλωσαν πως δεν έχουν ενημερωθεί σχετικά με μεθόδους και τεχνικές για τη διαφοροποίηση του διδακτικού πλαισίου στο μάθημα της μουσικής αγωγής. Επιπλέον, κανένας από τους εκπαιδευτικούς στις συνεντεύξεις δεν αναφέρθηκε σε διαβαθμισμένα επίπεδα δυσκολίας και στην ομαδοσυνεργατική διδασκαλία, στοιχεία απαραίτητα για τη σωστή εφαρμογή της διαφοροποιημένης μορφής μάθησης (Standferer, 2011).

Παρόμοια αποτελέσματα από έρευνες του εξωτερικού όπου οι εκπαιδευτικοί μουσικής εμφανίζονταν απροετοίμαστοι για να διαφοροποιήσουν τη διδασκαλία τους (π.χ. Salvador, 2010) οδήγησαν σε επιπλέον διερεύνηση του τρόπου προετοιμασίας των εκπαιδευτικών μουσικής αγωγής για τη διδασκαλία μαθητών με ειδικές εκπαιδευτικές ανάγκες, του επιπέδου προετοιμασίας τους στις προπτυχιακές σπουδές, καθώς και των δυνατοτήτων επιμόρφωσης που τους παρέχονται. Σε κάποιες από τις έρευνες που εκπονήθηκαν στις Η.Π.Α. κατά την τελευταία πενταετία, αρκετοί εκπαιδευτικοί μουσικής αγωγής δήλωσαν πως τα μαθήματα που παρακολούθησαν σε προπτυχιακό επίπεδο και οι ευκαιρίες για επιμόρφωση, τους προετοίμασαν επαρκώς για την ένταξη μαθητών με ειδικές ανάγκες στις τάξεις τους (Bernstorf, 2014· Hammel & Gerrity, 2012). Η έγκαιρη προετοιμασία για τη διδασκαλία μαθητών με ειδικές εκπαιδευτικές ανάγκες, με μαθήματα και τεχνικές που εστιάζουν στην μουσική αγωγή τόσο μέσω ένταξης μαθημάτων στις προπτυχιακές σπουδές όσο και με τη δυνατότητα επιμορφωτικών σεμιναρίων και προγραμμάτων συνεχιζόμενης εκπαίδευσης, φαίνεται πως μπορεί να αποτελέσει ένα βήμα για την ουσιαστική κατάρτιση των εκπαιδευτικών μουσικής και τη διδασκαλία των μαθητών με ειδικές εκπαιδευτικές ανάγκες (Moss, 2015· VanWeelden & Whipple, 2014).

Εξάλλου, όπως αναφέρει η Moss (2015), μελλοντικά θα πρέπει να διερευνηθεί και να αναλυθεί τόσο ο τρόπος με τον οποίο οι εκπαιδευτικοί μουσικής αγωγής εκπαιδεύονται ή πρέπει να εκπαιδεύονται για τη διδασκαλία μαθητών με ειδικές εκπαιδευτικές ανάγκες όσο και το επίπεδο προετοιμασίας τους στις προπτυχιακές σπουδές, καθώς και οι δυνατότητες επιμόρφωσης που τους παρέχονται. Επιπλέον, καλό είναι να μελετηθούν οι διαδικασίες μέσα από τις οποίες ο εκπαιδευτικός μουσικής αποκτά τα απαραίτητα τυπικά προσόντα, τα οποία πιστοποιούν τη γνώση και την εμπειρία για τη διδασκαλία των συγκεκριμένων μαθητών (Moss, 2015).

Δυσκολίες στην εφαρμογή διαφοροποιημένων προγραμμάτων

Οι εκπαιδευτικοί παρατηρούν ότι εκτός από την έλλειψη κατάλληλης προετοιμασίας υπάρχουν πολλά πρακτικά ζητήματα τα οποία δυσχεραίνουν την όποια επιθυμία ενδέχεται να έχει ο εκπαιδευτικός μουσικής για εφαρμογή διαφοροποιημένης μορφής μάθησης. Κάποιες δυσκολίες οι οποίες αναφέρθηκαν στην παρούσα έρευνα αναφέρονται και σε προηγούμενες έρευνες, σύμφωνα

με τη βιβλιογραφική ανασκόπηση. Έτσι, επισημάνθηκαν ο μεγάλος αριθμός μαθητών που οι εκπαιδευτικοί συναντούν καθημερινά (Blair, 2009) και οι λίγες ώρες του μαθήματος στο εβδομαδιαίο πρόγραμμα των τάξεων (Crowder, 2011). Αυτή η έλλειψη χρόνου, σε συνδυασμό με τις απαιτήσεις της διαφοροποιημένης διδασκαλίας, δημιουργεί ψυχολογική πίεση στους εκπαιδευτικούς μουσικής αγωγής (Crowder, 2011). Όπως αναφέρει η Delaney (2011), ο εκπαιδευτικός μουσικής, με την αναγκαστική επαφή με έναν τόσο μεγάλο αριθμό μαθητών, χάνει την προσωπική επαφή με τους μαθητές και δεν καταφέρνει να γνωρίσει βαθύτερα τις ειδικές εκπαιδευτικές ανάγκες καθενός ξεχωριστά. Υπό αυτές τις συνθήκες, ο εκπαιδευτικός δεν μπορεί εύκολα να προχωρήσει σε εφαρμογή κατάλληλα διαφοροποιημένων προγραμμάτων (Delaney, 2011). Επίσης, οι συμμετέχοντες εκπαιδευτικοί μουσικής αναφέρθηκαν σε δυσκολίες που σχετίζονται με την οργάνωση και υποδομή του σύγχρονου σχολείου, όπως τα χαμηλά επίπεδα συνεργασίας με συναδέλφους ειδικής αγωγής και παράλληλης στήριξης και τις οικογένειες των μαθητών με ειδικές εκπαιδευτικές ανάγκες. Οι συμμετέχοντες φαίνεται να αναγνωρίζουν τα θετικά αποτελέσματα που μπορεί να έχει η στενή συνεργασία με άλλους συναδέλφους, ενώ η σχετική βιβλιογραφία επιβεβαιώνει τη σπουδαιότητα της συνεργασίας μεταξύ των εκπαιδευτικών μουσικής και των συναδέλφων της ειδικής αγωγής για την επιτυχή ενσωμάτωση των μαθητών με ειδικές εκπαιδευτικές ανάγκες (Whipple & VanWeelden, 2012).

Επιπλέον κωλύματα στην υλοποίηση διαφοροποιημένων προγραμμάτων διδασκαλίας προκύπτουν από την έλλειψη οικονομικής αλλά και θεσμικής συμβολής από την πολιτεία, όπως είναι η ενίσχυση για το παιδαγωγικό έργο τους, η ύπαρξη υλικοτεχνικής υποδομής και αίθουσας μουσικής στα σχολεία. Σχετικές νομοθετικές ρυθμίσεις μπορούν να αποτελέσουν τη βάση για την ομαλότερη λειτουργία του εκπαιδευτικού συστήματος (Καραμητρόπουλος, 2015) και στη συγκεκριμένη περίπτωση τον χώρο για την εφαρμογή διαφοροποιημένων προγραμμάτων που θα ενισχύσουν τους μαθητές με ειδικές εκπαιδευτικές ανάγκες.

Περιορισμοί έρευνας

Η συγκεκριμένη έρευνα έχει περιορισμούς που σχετίζονται με τον αριθμό και την προέλευση των συμμετεχόντων, μιας και μελετήθηκαν οι απόψεις εκπαιδευτικών με αρκετά χρόνια προϋπηρεσίας (περισσότερα από δέκα). Επιπλέον, οι συμμετέχοντες υπηρετούν σε συγκεκριμένο γεωγραφικό διαμέρισμα της χώρας (περιοχή Α΄ Αθήνας) και σε μία βαθμίδα εκπαίδευσης (πρωτοβάθμια). Τέλος, το δείγμα ενδεχομένως να είναι θετικά προδιατεθειμένο ως προς το θέμα της διαφοροποιημένης διδασκαλίας μιας και δέχτηκαν να συμμετάσχουν στη συγκεκριμένη έρευνα.

Προτάσεις για μελλοντικές έρευνες και πρωτοβουλίες

Οι διαφοροποιημένες μέθοδοι διδασκαλίας και ειδικότερα η εφαρμογή τους στο μάθημα της μουσικής αγωγής αποτελούν ένα σχετικά νέο πεδίο ερευνών, και πολλές πτυχές του ζητήματος χρήζουν περαιτέρω μελέτης και έρευνας. Είναι σημαντικό, το έργο του Έλληνα εκπαιδευτικού μουσικής αγωγής να υποστηριχθεί μέσα από στοιχεία και αποτελέσματα μίας σειράς ερευνών που θα εκπονηθούν και θα συμπεριλαμβάνουν μεγαλύτερο δείγμα εκπαιδευτικών και από τις δύο σχολικές βαθμίδες εκπαίδευσης, με ποικίλο ακαδημαϊκό υπόβαθρο, εκπαιδευτική εμπειρία και

επιμόρφωση στη διαφοροποιημένη διδασκαλία. Με αυτόν τον τρόπο, θα είναι εφικτή η διαμόρφωση προτάσεων για τη σωστή προετοιμασία των εκπαιδευτικών σε επίπεδο σπουδών, καθώς και για τη συνεχή επιμόρφωσή τους σχετικά με τις καινούριες εφαρμογές παιδαγωγικών μεθόδων, όπως είναι η διαφοροποιημένη διδασκαλία.

Εξίσου σημαντικό είναι να διερευνηθούν και άλλες μεταβλητές που πιθανόν να επηρεάζουν τις στάσεις και τις διδακτικές επιλογές των εκπαιδευτικών μουσικής, όπως είναι για παράδειγμα αυτές που σχετίζονται με τις πολιτικές προώθησης της συνεργασίας μεταξύ των εκπαιδευτικών διαφόρων ειδικοτήτων, με το ωράριο του μαθήματος της μουσικής όπως αυτό προβλέπεται στα αναλυτικά προγράμματα και με την ύπαρξη της απαραίτητης υλικοτεχνικής υποδομής στις εκπαιδευτικές μονάδες.

Επίσης, η συνεργασία εκπαιδευτικών μουσικής με μουσικοθεραπευτές στο πλαίσιο της διδακτικής πράξης θα αποτελούσε μία εξαιρετικά ενδιαφέρουσα πρόταση και θα πρόσφερε καλύτερες προοπτικές στην εκπαίδευση μαθητών με ειδικές εκπαιδευτικές ανάγκες. Οι μουσικοθεραπευτές, πέραν των ατομικών και ομαδικών συνεδριών μουσικοθεραπείας, μπορούν επίσης να συνεργαστούν ως κλινικοί σύμβουλοι στη χρήση της μουσικής με τα υπόλοιπα μέλη της σχολικής κοινότητας. Με βάση την εκπαίδευση, την εμπειρία τους και το κλινικό έργο στον χώρο της ειδικής αγωγής μπορούν να προσφέρουν σημαντική βοήθεια στον προσδιορισμό των αναγκών των μαθητών με διαφορετικές δεξιότητες και στην ανάπτυξη μουσικών δραστηριοτήτων κατάλληλων για την ανάπτυξη και εκπαίδευση όλων των μαθητών σε κάθε τάξη.

Επιπρόσθετα, οι εκπαιδευτικοί μουσικής αγωγής που αποτέλεσαν το δείγμα στην παρούσα έρευνα επιλέχθηκαν με βασικό κριτήριο την εκπαιδευτική τους εμπειρία. Επιδίωξη των ερευνητριών ήταν να διαπιστωθεί κατά πόσο ο παράγοντας «εκπαιδευτική εμπειρία» μπορεί να βοηθήσει τους εκπαιδευτικούς να ανταπεξέλθουν στις ειδικές εκπαιδευτικές ανάγκες μαθητών αξιοποιώντας μόνο τη διδακτική τους εμπειρία και την αυτενέργεια κατά τη διδασκαλία τους.

Εντούτοις, μια ενδιαφέρουσα προσέγγιση θα ήταν η επανάληψη της έρευνας με δείγμα εκπαιδευτικούς μουσικής αγωγής με μικρότερη διδακτική εμπειρία. Ενδεχομένως ως νεότεροι να διαθέτουν ένα διαφορετικό επίπεδο σπουδών και εκπαιδευτικής εμπειρίας, που θα έδινε μια άλλη οπτική στο προπαρασκευαστικό δυναμικό των εκπαιδευτικών. Μέσα από μία τέτοια προσέγγιση μπορούν να διαπιστωθούν αλλαγές που έχουν τυχόν επέλθει στην προετοιμασία των εκπαιδευτικών μουσικής και να προσδιοριστούν οι ανάγκες τους.

Επιπλέον, καλό θα ήταν να διερευνηθεί ο συσχετισμός της επίδρασης όλων των προαναφερθέντων παραγόντων στη διαμόρφωση των απόψεων των εκπαιδευτικών για την εφαρμογή της διαφοροποιημένης προσέγγισης (Moss, 2015). Με τη χρήση διαφορετικών μεθοδολογιών (για παράδειγμα μικτή μεθοδολογία έρευνας) είναι εφικτό να προσδιοριστούν στοιχεία που ενδεχομένως αποτελούν ανασταλτικό παράγοντα στη διαφοροποιημένη διδασκαλία, καθώς και στοιχεία που τυχόν επηρεάζουν τους εκπαιδευτικούς μουσικής σε σχέση με την αυτενέργεια, τη διδακτική επάρκεια και την αξιολόγηση της αποτελεσματικότητας της διαφοροποιημένης διδασκαλίας.

 Τέλος, αναγκαία φαίνεται να είναι η οργάνωση προγραμμάτων επιμόρφωσης και συνεχιζόμενης εκπαίδευσης για εκπαιδευτικούς μουσικής καθώς και η εισαγωγή μαθημάτων σε προπτυχιακό και μεταπτυχιακό επίπεδο μουσικών σπουδών τα οποία θα σχετίζονται με τη διαφοροποιημένη διδασκαλία και την ένταξη μαθητών με ειδικές ανάγκες στο μάθημα της

μουσικής. Έτσι, ο εκπαιδευτικός μουσικής θα έχει την κατάρτιση και τις απαραίτητες γνώσεις και εμπειρίες ώστε να υλοποιήσει διαφοροποιημένες μεθόδους διδασκαλίας με τρόπο που να αρμόζει στις σύγχρονες διδακτικές προσεγγίσεις και στα σύγχρονα ελληνικά εκπαιδευτικά δεδομένα.

ΠΑΡΑΡΤΗΜΑ

Ερωτηματολόγιο συνεντεύξεων

- Ποιος είναι ο ανώτερος τίτλος σπουδών σας;

- Πόσα χρόνια προϋπηρεσίας έχετε στη δημόσια πρωτοβάθμια εκπαίδευση;

- Έχετε δεχτεί κάποια επιμόρφωση για τη διδασκαλία σε μαθητές με ειδικές εκπαιδευτικές ανάγκες;

- Έχετε δεχτεί κάποια επιμόρφωση σχετικά με την εφαρμογή διαφοροποιημένων προγραμμάτων για το μάθημα της μουσικής αγωγής;

- Θα μπορούσατε, σύντομα, να δώσετε μία περιγραφή της «Διαφοροποιημένης Διδασκαλίας»;

1. Έχετε διδάξει ποτέ σε μαθητή-τρια με ειδικές εκπαιδευτικές ανάγκες; Αν ναι, τι περιπτώσεις;

2. Έχετε επαρκή πληροφόρηση (γραπτή ή προφορική) για τους μαθητές με ειδικές εκπαιδευτικές ανάγκες στα τμήματα που διδάσκετε;

3. Είστε της άποψης πως η διδασκαλία της μουσικής σε μαθητές με ειδικές εκπαιδευτικές ανάγκες απαιτεί διαφοροποίηση της τυπικής διδασκαλίας που εφαρμόζεται στη γενική τάξη;

4. Θεωρείτε ότι έχετε προετοιμαστεί κατάλληλα κατά την εκπαίδευσή σας για να διδάξετε μαθητές με ειδικές εκπαιδευτικές ανάγκες και να διαφοροποιήσετε τη διδασκαλία σας;

5. Πιστεύετε πως η εκπαιδευτική εμπειρία σάς βοηθάει να ανταπεξέλθετε στις ανάγκες μαθητών με ειδικές εκπαιδευτικές ανάγκες διαφοροποιώντας τη διδασκαλία σας;

6. Αισθάνεστε υπεύθυνος/η για τη διδασκαλία μαθητών με ειδικές εκπαιδευτικές ανάγκες, όταν αυτοί υπάρχουν στη γενική τάξη;

7. Θεωρείτε πως η εφαρμογή διαφοροποιημένων μεθόδων διδασκαλίας στη μουσική επηρεάζει θετικά τις επιδόσεις των μαθητών με ειδικές εκπαιδευτικές ανάγκες; Αν ναι, με ποιον τρόπο;

8. Έχετε εφαρμόσει ποτέ κάποιο διαφοροποιημένο πρόγραμμα διδασκαλίας στο πλαίσιο διδασκαλίας της μουσικής, ώστε αυτό να ανταποκρίνεται σε μαθητή/τρια με ειδικές εκπαιδευτικές ανάγκες; Αν ναι, αναφέρετε κάποια παραδείγματα.

9. Πόσο συχνά εφαρμόζετε διαφοροποιημένα προγράμματα στο πλαίσιο διδασκαλίας της μουσικής σε τμήματα με μαθητές/τριες με ειδικές εκπαιδευτικές ανάγκες;

10. Πώς αισθάνεστε όταν εφαρμόζετε κάποιο διαφοροποιημένο πρόγραμμα στη μουσική σε τμήμα με μαθητές/τριες με ειδικές εκπαιδευτικές ανάγκες;

11. Σύμφωνα με την εμπειρία σας, θεωρείτε πιο δύσκολο να εφαρμόσετε πρόγραμμα διαφοροποίησης διδασκαλίας σχεδιασμένο για μαθητές με συναισθηματικές ή γνωστικές αναπηρίες; Παρακαλώ, δικαιολογήστε την απάντησή σας.

12. Πιστεύετε πως υπάρχουν δυσκολίες στην εφαρμογή διαφοροποιημένων προγραμμάτων στη μουσική; Αν ναι, ποιες θεωρείτε τις πιο σημαντικές και τι πιστεύετε ότι θα σας βοηθούσε να τις ξεπεράσετε;

13. Χρειάζεται να αφιερώσετε επιπρόσθετο χρόνο στην προετοιμασία σας για τον σχεδιασμό και την εφαρμογή διαφοροποιημένου προγράμματος σε σχέση με την τυπική διδασκαλία;

14. Θεωρείτε ότι ο αριθμός των σεμιναρίων ή εργαστηρίων που προσφέρονται σχετικά με την οργάνωση και εφαρμογή διαφοροποιημένων προγραμμάτων στο μάθημα της μουσικής αγωγής για τη διδασκαλία μαθητών με ειδικές εκπαιδευτικές ανάγκες είναι επαρκής;

15. Επιδιώκετε την ενημέρωση και τη συνεργασία των γονέων των παιδιών με ειδικές εκπαιδευτικές ανάγκες για την καλύτερη επιτυχία των διαφοροποιημένων προγραμμάτων κατά την εφαρμογή τους;

16. Σε περίπτωση ενημέρωσης γονέων, ποια έχετε διαπιστώσει πως είναι η στάση των γονέων των συγκεκριμένων παιδιών απέναντι στα διαφοροποιημένα προγράμματα που εφαρμόζετε;

17. Ποια είναι η στάση της διεύθυνσης του σχολείου απέναντί σας, όταν αποφασίζετε να εφαρμόσετε κάποιο διαφοροποιημένο πρόγραμμα; Υπάρχει κατανόηση απέναντι στις προκλήσεις και δυσκολίες που μπορεί να αντιμετωπίσετε;

18. Θεωρείτε ότι υπάρχει η κατάλληλη ενημέρωση, υποστήριξη και συνεργασία από τους συναδέλφους της ειδικής αγωγής κατά την εφαρμογή διαφοροποιημένων προγραμμάτων στο μάθημά σας; Υπάρχει ανταπόκριση από τους συγκεκριμένους συναδέλφους όταν ζητάτε τη βοήθειά τους;

19. Θεωρείτε πως το Υπουργείο Παιδείας διευκολύνει ή δυσχεραίνει με τις πολιτικές και πρακτικές του κάθε προσπάθεια αξιοποίησης διαφοροποιημένων προγραμμάτων από μέρους σας; Παρακαλώ επιχειρηματολογήστε.

20. Τι πιστεύετε πως θα σας βοηθούσε, ώστε να διδάξετε πιο αποτελεσματικά το μάθημα της μουσικής αγωγής και να εφαρμόσετε διαφοροποιημένα προγράμματα διαδασκαλίας σε μαθητές με ειδικές εκπαιδευτικές ανάγκες; Σε επίπεδο: Α. Σπουδών, Β. Εκπαιδευτικής Κοινότητας, Γ. Οικογένειας, Δ. Κοινωνίας.

21. Έχετε να κάνετε κάποια παρατήρηση για τη βελτίωση και την εφαρμογή των διαφοροποιημένων προγραμμάτων στο μάθημα της μουσικής;

Θα θέλατε κάτι άλλο να προσθέσετε;

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Differentiated teaching in music educations: Views and concerns of primary school music teachers

Katerina Keramida | Potheini Vaiouli

ABSTRACT

Differentiated instruction is a contemporary teaching approach that aims to better educate students with special educational needs. By applying differentiated instruction strategies, the music class can foster students' cognitive development and may contribute to their socio-emotional growth. The purpose of this study was to investigate music educators' perspectives, their knowledge and their level of preparation regarding differentiated instruction. To this end, semi-structured interviews were conducted with in-service primary school music teachers with a focus on differentiated instruction practices in Greek, public schools. The results of the research pinpoint to the need for enhancing the work of music educators and for further investigating this area of work in Greece.

KEY WORDS

music education, primary education, differentiated instruction, special educational needs

BOOK REVIEW

An introduction to music therapy research (Wheeler & Murphy, Eds.)

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Patricia Winter, PhD, MT-BC, is Assistant Professor of Music at Radford University, VA, USA. She has been a clinical music therapist for 18 years serving clients from diverse backgrounds. Currently, she serves preschool-aged children with speech and language disorders. Her research interests include the impact of music therapy on the development of play skills in young children as well as cultural competence when implementing music therapy in a foreign country as a result of her ongoing work in Malawi, Africa. [pwinter3@radford.edu]

In the early 2000s I entered a master's degree programme in music therapy and began my development as a researcher. Wheeler's second edition of *Music Therapy Research* was the 'go to' book for quantitative and qualitative music therapy research design and implementation. The second edition became a valuable resource for every one of my master's and doctoral projects. When I learned that Wheeler was working on a third edition I was delighted as the second edition was quite dated (published in 1995) and it did not include mixed methods research or the use of technology as a valuable tool for the researcher. It was even more exciting to see that she had added Kathy Murphy as a co-editor given the scope of Murphy's work as a music therapist and writer in the discipline.

The release of *An Introduction to Music Therapy Research* provides a very important and valuable addition to the educational resources available for music therapy students and for academics tasked with teaching research. The shorter book provides students and academics with a condensed, digestible resource for new researchers both at the undergraduate and graduate levels. Students are afforded an overview of historical and theoretical underpinnings of research germane to the profession of music therapy, several research paradigms, strategies for data collection, data analysis and/or evaluation of data as well as guidelines for writing and submitting research for publication. It must be said that the true heart of this book is the editors' and authors' commitment to the profession of music therapy, the deep engagement with the extant music therapy literature and the consistent framework that positions music therapy research and practice always as the focus of the conversation.

This edited book contains 20 chapters written by eminent music therapy researchers. These chapters prepare the reader to understand the complex dynamics of both objectivist and interpretivist orientations to research. Wheeler and Murphy moved to this language because they

thought that it "made some of the bigger issues clearer" (Wheeler & Rickson, 2018, p. 83). Wheeler identifies that the move to objectivist and interpretivist language came from the "broader literature" and that it is "consistent with other writing". It is the hope of the editors that "music therapists will find the changes useful while still being able to talk with others about 'quantitative' and 'qualitative' methodologies" (Wheeler & Rickson, 2018, p. 83). This choice seems important as it calls researchers to clarify their epistemological stance in order to demarcate their research approaches. However, Wheeler and Murphy have constructed the text in such a way as to avoid the creation of research 'camps' and have levelled the playing field between the two paradigms. This editorial choice challenges the reader to use the best orientation to get to the bottom of the research question rather than intentionally or unintentionally placing an emphasis on one orientation over another.

Evident in this book is a dedicated focus to defining objectivist and interpretivist research paradigms and the positioning of research methodologies within these paradigms. The format of the book and the continued dedication to these ideals is in line with the educational theory of a spiral curriculum in which key concepts are introduced and then repeated in ever-increasing degrees of complexity. The spiral presented across the 20 chapters is iterative rather than linear and contributes to a further deepening of the reader's understanding not only of the research paradigms but also the many ways in which these paradigms have already been at play in the music therapy literature. The editors did not stop there as they also included authors who elaborated on the implications for the future of music therapy research as an essential component of the development of the profession.

Chapter one begins with Wheeler and Bruscia offering a clear and compelling description of the practice and theory of research. It is within this chapter that the building blocks are constructed to provide a foundation for the rest of the book. Definitions and clear explanations of objectivist and interpretivist paradigms are provided for the reader and the constructs of epistemology and ontology are explored and delimited. It is within this chapter that the reader will find a nod to mixed methods research and the role of this method of research both inside and outside of the profession of music therapy. This is important because it demonstrates an increasing acceptance and valuing of mixed methods approaches within the profession of music therapy and beyond.

Several chapters were very exciting to me as a music therapy educator of undergraduate and graduate students and I know that I will be assigning chapters four, six, 19, and 20 as required course readings. Each of these chapters provides valuable information in an accessible way and covers topic areas such as thinking as a culturally competent researcher, interacting with the mechanisms that provide access to research as well as strategies for engaging with research studies. Chapter six, written by Kim and Elefant, contains multicultural considerations and provides a powerful statement about the responsibilities of the researcher as she/he engages with clients from diverse cultural backgrounds. The positioning of this chapter very early in the book and directly after Murphy's chapter on ethical considerations is worthy of applause. Kim and Elefant articulate the importance of culturally sensitive research design and charge researchers to be aware of their own cultural competence and cultural biases.

Abbott reminds us in chapter four of the vital importance of a thorough search of the literature and offers the reader clear guidelines to complete a comprehensive search. She introduces search engines, key terms, and Boolean operators in a very user-friendly manner. Her inclusion of graphic

organisers creates an interface that represents current trends in research reporting, making the information very functional for those who are beginning their journey as researchers.

Chapter 19, written by Meadows, addresses each section contained within an objectivist research article, explains the importance of each section, and includes recommendations for how to read and understand research, how to critique research, and considerations for writing from an objectivist standpoint. Chapter 20, written by Gardstrom, is the companion to Meadow's chapter and focuses on interpretivist research. Of note is Gardstrom's emphasis on the importance of reader engagement with the literature, including why one should read research, how to 'dig into' the readings, sage advice to read an article multiple times, and thoughts about taking and making notes when engaging with interpretivist literature. Gardstrom writes "consider that visually scanning a score without actualizing/hearing the music would be somewhat like professing to comprehend the taste of a cake by scanning the ingredients of the recipe!" (p. 223).

Throughout this book research is presented with love and care, not only for the research product but also the research process. Our client's worlds are held inside research publications and these publications serve to improve our quality of care for those whom we serve. The charge for deep, emotional, physical, cognitive, musical and sometimes spiritual engagement with the research is a powerful statement about its importance to the profession.

Another way that life is imbued into this book is through the rich metaphors of movement and travel. Merrill and Keith describe ways in which the research and the researcher are on a journey and the ways in which music therapy research is indicative of our collective journey. Chapter two, written by Merrill, is an historical portrait of music therapy, full of rich imagery, positioning music therapy research as moving water that begins as headwaters and leads to a delta. This beautiful and poignant description evokes a feeling of movement, growth, change and development. Her choice to stop at the image of a delta is powerful, calling upon the reader to join the flow of research as it continues on to greater and greater bodies of water. Chapter 13 continues the metaphor of movement and travel as Keith describes his pilgrimage on the Camino de Santiago and explores how this experience illuminated the fact that researchers are curious participants who engage with their environment in ways that are indicative of the foundations of strong research practice.

It is apparent that the editors took great care to alternate chapters on objectivist research with chapters on interpretivist research. This back and forth conversation between the two orientations is unique and refreshing, allowing the reader to think about a particular component of research design and then weigh the benefits or challenges of each orientation. If one is a new researcher and just learning the language of research design and the processes for implementation, data collection and analysis, this back and forth could provide a nice balance so that the novice researcher can weigh her/his options before developing a research bias. The strategy for organising the book does not appear to position one orientation as having prominence over another. By avoiding the typical research textbook design of one orientation dominating the front of the book and one dominating the back the editors are avoiding making overt or subtle statements that one paradigm is more important than another.

However, a downfall inherent in the back and forth conversation is the feeling that I am watching a tennis match. This is not a distasteful pursuit but I know nothing about tennis so for me a tennis match is just a ball bouncing back and forth with no framework for understanding the scoring,

the rules or the history. While this book sets up the reader with a foundational understanding of key terms, ideas, components and history, at times the back and forth did not provide clarity, rather it muddled the information into a big research soup. For a new or novice researcher the text can be quite heady and several chapters imply a research vocabulary that the reader may or may not possess. As an educator I have to wonder if the back and forth will cause more confusion than clarity of understanding. As a more seasoned researcher and reader of research I found myself continually switching back and forth between my understanding of objectivist and interpretivist research and the information presented in the book. Of course, this may be indicative of my own research bias. I feel infinitely more comfortable with the objectivist paradigm and felt that I knew much of the information presented. While I have a deep respect for interpretivist research I also find it vague and a bit harder to grasp, creating a sense of anxiety about the content area. I found myself spending more time with the interpretivist chapters gleaning everything I could from the authors. The act of jumping between paradigms then became a challenge as the confluence of ideas was at times overwhelming. If I am to teach from this book, I will most likely assign the interpretivist readings in a chunk and the objectivist readings in a chunk in order to maintain a sense of cohesion between the two paradigms. My take away from the construction of this text is to maintain awareness of my biases and to think carefully about how I position each chunk to alleviate any implications that one paradigm has more value than the other.

As mentioned above this book would be a wonderful addition to an undergraduate or graduate level research course; it implies, however, a working knowledge of research terminology or engagement with a researcher/educator/mentor who can supplement student learning with definitions of concepts. Chapter 11, for example, written by Sullivan and Sullivan, begins by identifying that Type I and Type II errors are problematic within objectivist research. These concepts are not defined until chapter 12, although they are quite important for an understanding of the inherent problems associated with this paradigm. I think a new researcher with little to no research experience would struggle to understand this issue without some additional support.

I highly recommend this book for new or novice researchers who have a support system that can provide guidance with some of the concepts that may be more difficult to understand. I would also recommend this book to educators who have a working knowledge of research or research experience and who are teaching an undergraduate or graduate level introduction to research course. I found that many of the chapters can be implemented across the music therapy curriculum even in classes where there is not a dedicated focus on research. This book would be less useful for the advanced researcher, however, if the reader is new to one of the paradigms and would like to begin exploring either interpretivist or objectivist perspectives, this text provides an approachable introductory resource for engagement with the foundational principles within each paradigm.
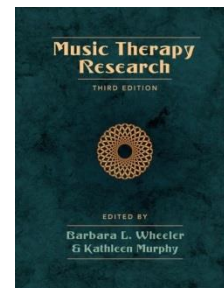
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BOOK REVIEW

Music therapy research (3rd ed., Wheeler & Murphy, Eds.)

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Barbara Wheeler is a name synonymous with research in the profession of music therapy. In 1995 she was the sole editor of the second edition of *Music Therapy Research*, which contained 24 chapters exploring quantitative, qualitative, historical, and philosophical approaches to research. Twenty-one years later she brought on Kathy Murphy as co-editor for the release of the third edition. This updated edition includes an impressive 68 chapters that situate music therapy research into objectivist and interpretivist paradigms, outline research ethics and multicultural considerations, and provide an impressive number of research designs and approaches that can be employed toward the deepening of our understanding of music therapy.

Wheeler begins the preface by identifying the "tremendous growth" of the music therapy profession over the "last 65 years," and firmly establishes that "our research" allows us to "understand how music is used within the context of a therapeutic relationship" (p. xvii). Given the breadth and scope of this text, it is clear that research in music therapy is alive and well, and that we are moving into an era where we are now, more than ever, using research to generate an evidence base that is currently serving us and will serve us into the future.

One of the most impressive features of this text is that each chapter is tied to the extant music therapy research. Well-established research methodologies such as survey research (Chapter 27), longitudinal designs (Chapter 31), factorial designs (Chapter 36), phenomenological inquiry (Chapter 40), hermeneutic inquiry (Chapter 42), and historical research (Chapter 62) are clearly defined and articulated. Within each chapter, the authors have provided examples from the music therapy literature and guidelines for implementation of the methodology. It is apparent that the authors and editors took great care in outlining the powerful ways in which each research design has been used and can be used to further explore questions that arise through the practice of music therapy. Each

chapter includes resources from eminent researchers and theorists both inside and outside of the profession of music therapy. When reading about interpretivist case-study research (Chapter 53), I expect to see names such as Yin, Corbin and Strauss, and Creswell, as they are experts in interpretivist research and in case-study design. What makes this book exciting is that these important figures are sharing the page with influential music therapy researchers such as Aigen, Bruscia, McFerran and O'Grady. While I struggle with our propensity to define music therapy through the lens of other professions, I find this approach of connecting researchers inside and outside of the discipline to be highly satisfying, as it aligns the expertise of music therapy researchers with a larger community of researchers and research experts while acknowledging the unique demands that are faced by music therapy researchers.

Wheeler and Murphy's dedication to the inclusion of research designs that are coming to the fore within our profession and within medical and humanities research is encouraging, as it helps the reader to seek the design that best answers the research question, rather than using a research design that is perceived to have more value. This also provides researchers with new and emerging research approaches in order to avoid "methodolatry or the habitual attachment to a particular method" (Darrow, p. 47). A professional emphasis on evidence-based practice could sway music therapists to only consider the "gold standard" of research, the randomised controlled trial, as the best or most important research when reading or designing a study. Felicity Baker and Laurel Young address the relationship between research and practice in Chapter 3, where they outline a hierarchy of evidence adapted from the Oxford University Centre for Evidence-Based Medicine's Levels of Evidence. At the top of this list is the "systematic review of several experimental research studies showing homogeneity of results," (p. 27), such as the Cochrane reviews. Toward the bottom of the list one finds the "single case-control study" (p. 27). In a section on the Cochrane reviews and systematic reviews, Baker and Young write "only studies ranked Level 1 allow us to reliably conclude whether a cause-and-effect relationship exists between music therapy and outcomes. However, one should not overlook the findings of studies ranked at Levels 3 and 4" (p. 28).

The 3rd edition highlights that high quality research can occur through a wide variety of practices and that in combination these practices provide a foundation of evidence that is as rich and fertile as the profession itself. The inclusion of single-subject and small *n* approaches (Chapters 24-26), arts-based research (Chapter 44), grounded theory (Chapter 49), thematic analysis (Chapter 52) and microanalysis (Chapters 54 and 55) are just an example of the diverse array of research methodologies that are outlined, allowing researchers and clinicians access to theoretical paradigms and research processes that can lead one to discover the inherent depth of the practice of music therapy. Of note is Michael Viega and Michelle Forinash's definition of arts-based research; a research method and an overall methodology "where a creative worldview forms the philosophical foundation for an inquiry" (p. 491). It is through these diverse lenses that music therapists can explore and develop theory and practice, create protocols that best meet the needs of clients, honour the art and science of the profession, and grow the research base to meet the ever-changing needs of a rapidly evolving culture of healthcare.

In the 3rd edition Wheeler and Murphy decided to move from identifying research as either quantitative or qualitative and redefining the paradigms as objectivist or interpretivist. This change in terminology is important, and is consistent within the third edition as well as within the condensed

Introduction to Research (Wheeler, & Murphy, 2017). Rickson (2018) interviewed Wheeler to discuss her choice of using objectivist and interpretivist language over quantitative and qualitative. It is Wheeler's hope that this move will increase our opportunities to converse in multi- and interdisciplinary settings rather than hinder those opportunities.

In order to address the move to objectivist and interpretivist language, the editors have included several chapters that prepare the reader for engaging with these concepts before delving into the many research designs that are outlined within the next 40 chapters of the book. Winter (2017) offers a further review of these preparatory chapters, as they are also included in the *Introduction to Research* book by Wheeler and Murphy (2016). The format for both of these books is in line with the "educational theory of a spiral curriculum in which key concepts are introduced and then repeated in ever increasing degrees of complexity" (Winter, 2017, p. 2). The spiral is "iterative rather than linear and contributes to a further deepening of the reader's understanding not only of the research paradigms but also the many ways in which these paradigms have already been at play in the music therapy literature" (p. 2).

Some additional features that prepare the reader to engage with research include chapters on the relationship between research and practice (Chapter 3), the relationship between research and theory (Chapter 4), developing a topic (Chapter 5), reviewing the literature (Chapter 6) and funding research (Chapter 10). These highly accessible chapters are useful for new or novice researchers who are planning to conduct research, for a senior-level or introductory graduate-level research course, or for those who are skilled at research but may need to engage with updated literature on the topic.

Chapter 5, developing a topic, provides a useful overview of the processes one may use to hone a research question into a feasible research study. Alice Ann Darrow's focus on the sincerity and trustworthiness of a "good" researcher is a powerful statement that emphasizes the incredible responsibility researchers have to clients/ participants and to the profession. I do, however, challenge Darrow's statement that we are to have a "mind free of biases and preconceived notions of where the research will lead" (p. 47). I have to wonder if it is possible to approach research without some preconceived notions of where the research may lead? Is it possible to have a mind free of biases? In Chapter 20, *Data Collection in Interpretivist Research*, Doug Keith writes, "when researchers collect data, their method flows from a purpose. This is true irrespective of the theoretical orientation of the researcher […] each purpose is rooted in a particular epistemology and theoretical perspective" (p. 231). This may imply that researchers come to the research question(s) already situated within an orientation, and that that orientation can create notions of where the research may lead. It may be more helpful to explain that researchers and clinicians come to research questions with biases, some of which lead us to the research question in the first place. The possibility that our findings will align with our hypothesis can be exciting and often sustains our engagement with a project that may be difficult, frustrating and challenging. In Chapter 40, *Phenomenological Inquiry*, Nancy Jackson describes the importance of the epoché and bracketing to help the researcher recognise and move away from "one's own beliefs, judgments, prejudices, biases, and preconceptions about the phenomenon being studied" (p. 442) and to serve as tools to help us "consciously put aside identified biases, assumptions, and so forth" (p. 442). Through the removal of these preconceived ideas the "researchers can be open to as many different variations of the phenomenon as the data

contain" (p. 443). Perhaps we do not come to the research without bias, but we strive to be aware of the notions we bring to the project and are continually tasked with exploring, acknowledging, and countering the impacts of these notions on the potential outcomes of the study.

One potential notion that we bring to our research is that music is powerful and that music therapy changes people behaviourally, physically, cognitively, and spiritually. Within the third edition there are two chapters with a dedicated focus on the handling of musical data. In Chapter 15, *Measurement of Musical Responses*, Jörg Fachner offers approaches for measuring musical responses within an objectivist paradigm through the identification of dimensions of the music experience that include temporality, personal meaning and universal responses, emotional intensity, and expectations. Some of the methods for gathering and handling this information include participant self-report, researcher analysis of musical material, brain imaging via EEG, and analysis of biomarkers such as "neurotransmitters, hormones, cytokines, lymphocytes, vital signs, and immunoglobulins" (p. 159). Fachner examines the impact of music on the body and the mind, and presents research strategies that can help to access this powerhouse of information.

Chapter 21, *Analysing and Interpreting Musical Data in Interpretivist Research*, written by Lars Ole Bonde, is the companion chapter to Fachner's. Ole Bonde begins the chapter with a wake-up call to music therapists: "the music itself in music therapy could be given much more attention than is often the case in research studies" (p. 245). He then follows with the statement "given that music is the core medium of music therapy, it is surprising that only a few studies report more than superficially about the music itself" (p. 245). Ole Bonde articulates that analysis of music within music therapy is not an "end in itself" (p. 245). He then offers a list of several areas music therapists can evaluate in their research, such as inter- and intra-musical interactions, inter- and intra-personal interactions, influence of music on 'body, mind, and soul'" (p. 245), and changes in behaviour as a result of the music experience. Ole Bonde includes a chart of music therapy research articles from the *Nordic Journal of Music Therapy* and the *Journal of Music Therapy* from 2012-2015. Of the 46 research articles in the *Nordic Journal* and the 59 research articles in the *Journal of Music Therapy* only nine included a "minimum of phenomenological description of analysis of one musical episode/syntax-semantics" (p. 246). This information is quite shocking, and serves as a strong reminder to consider what I emphasise and what I report when designing and conducting research. Music therapy is a music-based profession and it would stand to reason that we would be reporting on the music as an essential component of our clinical work. Ole Bonde referrers to Ansdell's (1999) "music therapist's dilemma" (as cited in Bonde, p. 245), suggesting that it is difficult to discuss what happens in music therapy but that this discussion is essential to music therapy. Within Chapter 21 Ole Bonde suggests several methods for discussing the music that happens in music therapy, and conceptualises this process on a spectrum. His inclusion of a decision tree, "the spectrum of music analysis" (p. 247), positions research on a continuum rather than as an either/or phenomenon. This spectrum provides a number of options for researchers to consider when interpreting musical data, thereby uniquely visioning the handling of musical data through "more quantitative, mixed, or more qualitative" methods (p. 247), lending itself to an understanding of the various shades of researching music rather than as a rigidly defined, black and white, event involving music. Some of Bonde's recommendations for handling musical data include heuristic music analysis, phenomenological

descriptions, body listening, Bruscia's Improvisation Assessment Profiles, and microanalysis of traditional and graphic notation.

These two chapters are within Unit 4 and Unit 5 respectively. The two units address methodological concerns that emerge within each paradigm, and they contain chapters on measuring, analysing, and interpreting clinical data (Chapters 16 and 22), potential problems in objectivist research (Chapter 17), and software programs to help with the analysis of data (Chapters 19 and 23). Gene Ann Behrens' introduction to SPSS (Chapter 19) is notable in that it provides an incredibly user- friendly overview of a not-so-user-friendly system. She begins the chapter with two decision trees that the researcher can use to select the proper inferential or descriptive statistics for the research question. On the next page, Figure 3 outlines a case scenario which leads the reader through the kinds of research questions one may ask when designing a study. On the following pages there is a table that summarises the research questions from the previous figure, type of variables, levels of measurement, and statistical analyses for SPSS (pp. 206-207). Behrens has also included screen captures of an SPSS data set and screen captures of different parts of the SPSS program as she works through several different statistical analyses. These tools are incredibly useful, and I know that these pages especially will be the most worn, dog-eared, highlighted pages in my copy of the book. While I enjoy objectivist data analysis, I do not do it often enough to have this information stored handily in my brain, therefore I typically have had to turn to several different books and YouTube videos to find this level of support. Now all of this information is in one convenient location. Not only will I use this chapter to teach a graduate-level introduction to research course, to advise graduate-level theses and undergraduate research projects, but I will turn to it for my own decision-making when handling data for objectivist research studies.

Chapter 23, *Software Used in Data Analysis of Interpretivist Research*, by Felicity Baker, is the companion chapter to 19, and includes information that is equally as helpful. She highlights several interpretivist data-handling programs, including MAXQDA, ATLAS.ti, and NVivo. The inclusion of screen captures from each interface helps the reader to get a sense of the functionality of each program as she describes the types of features available within each one. While I know it is impossible to cover all of the data-analysis software programs, I would have included the cloud-based program Dedoose, which is user-friendly, well-suited for interpretivist research, and very well-suited for mixed-methods research as it provides options for mixing objectivist and interpretivist data sets.

Units 4 and 5 prepare the reader to engage with individual research designs, which are then outlined in Units 6-8. These subsequent units include designs within the objectivist and interpretivist paradigms, as well as chapters on other types of research such as mixed-methods designs, systematic reviews, historical research, and philosophical inquiry. The book concludes with a section on evaluating the reliability and validity of objectivist research (Chapter 65), evaluating the rigor and integrity of interpretivist research (Chapter 66), and reading, writing, and submitting objectivist and interpretivist research (Chapters 67 and 68).

The third edition of *Music Therapy Research* is what music therapy clinicians, researchers, academics, and students have needed. The editors have tapped into the international music therapy community as a resource for the incredibly rich research that has already been published within the profession. These authors have provided resources for research that include strategies and

guidelines for the creation, design, and implementation of ethical, culturally sensitive, and rigorous research. Within this book there are also guidelines for how one may engage with published research as an evidence base that drives clinical decision-making. After reading this book, I am excited about what the next 21 years of music therapy research will look like and how we will be better positioned to understand the true potentials of music therapy as a result of the collective voices of the music therapists who contributed to the third edition. As I conclude this review, I am left with a sense of pride in the profession, in our dedication to our clients, and our passion to seek the evidence that leads to ethical and culturally competent practice. I will use this book as an educational tool for undergraduate and graduate research, as a personal resource in both clinical work and research endeavours, and as a weighty reminder of our tremendous professional growth over the past 65 years.

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BOOK REVIEW

Music, health and wellbeing
(MacDonald, Kreutz & Mitchell, Eds.)

Reviewed by Fleur Hughes

Independent scholar, Canada

REVIEWER BIOGRAPHY
Fleur Hughes (MMT, MTA, MT-BC, NMT) completed her Masters in Music Therapy in 2015. Fleur is currently working in Calgary with adults who have a wide range of mental health and neurodevelopmental disorders. She works mainly in Long Term Care Settings. During 2017, Fleur presented and shared examples of her work at two conferences. The Online Conference for Music Therapy (OCMT) and The Improvisation and Mobility Conference and Festival which was held at the University of Regina (U.O.R.). In 2018, she will be starting a PhD in Music. [fleuralocinhughes@yahoo.ca]

The idea for this book grew from a conversation between MacDonald, Kreutz and Mitchell at a conference in 2008. They wanted "to bring together an international and multidisciplinary group of articles that reflected the breadth and depth of interest in the link between music, health, and wellbeing" (p. viii). This publication seems to accomplish this task and is a robust and thorough example of the relationship that is established between music and our wellbeing and health.

This book was originally published in 2012 and offers important contributions within the fields of music, wellbeing and health. These contributions are still relevant today, five years later. The contents consist of 34 chapters, which are subdivided into five different sections. Structuring the work into sections is useful for the reader, who can pick out relevant sections as required. The editors note that "one challenge for researchers is to sensitively evaluate the evidence available in this area where there are a multitude of approaches" (p. 7). To overcome this challenge, this publication is informed by a multidisciplinary and international panel of experts in their fields.

In this review I focus on specific chapters that I have found particularly relevant to the healthcare setting that I am working in. These chapters have been useful for shaping my approach with regard to being culturally informed, as I work with a culturally diverse caseload. Therefore, I would like to acknowledge all the authors who have contributed to the vast body of work that this book covers.

SECTION 1: INTRODUCTORY CHAPTERS: SETTING THE SCENE (CHAPTERS 1-4)

The first section provides an outline of the conceptual framework of the book. The book does do not focus solely on the clinical or therapeutic effects of music, but provides insight into music education, music therapy, community music and how we engage with music in our daily lives. Authors who contributed to this section (pp. 3-62) include Elliot and Silverman *Why Music Matters: Philosophical and Cultural Foundations* (pp. 25-39*)*. They discuss how music has impacted philosophy, society, education and can transform oneself. This takes place in musical practices, musical structure and experiences that involve participation and social engagement which can lead to self-growth and transformation. They state how music engages and stimulates us: "[…] music contributes to health and wellbeing in numerous ways because it interconnects the self as a unity – as a fluid and integrated matrix of body-brain-mind-conscious- and-unconscious systems […]" (p. 33).

SECTION 2: COMMUNITY MUSIC AND PUBLIC HEALTH (CHAPTERS 5-11)

The next section opens up to a broader body of research. Within chapter 7, *The New Health Musicians* (pp. 87-96), Ruud mentions how "Music is being increasingly recognized as a 'cultural immunogen'" (p. 87). The reader gains insight into the health and cultural benefits of group music making, and how this can assist in reducing stress and managing trauma. Ruud illustrates through a case study how a group of adolescents based in a refugee camp in Lebanon have been taking part in a community-based programme. Despite the challenges that were faced, the music programme did have positive effects. According to Ruud, the adolescents "experienced a markedly positive effect upon their sense of vitality, agent and belonging" (p. 91). It seems music has provided the opportunity for bonding with others, offering joy and pleasure and provides a meaningful and engaging experience.

SECTION 3: MUSIC AS THERAPY AND HEALTH PROMOTION (CHAPTERS 12-20)

This is the longest section in the book and chapters focus on music and health within therapeutic and clinical contexts. It is the longest section in the book and focuses on mental health and health in general. Chapter 14 (pp. 183-195) written by Stige, on *Health Musicking: A perspective on Music and Health as Action and Performance*, describes how music takes place with the context of a nursing home, using music to facilitate health benefits.

This chapter focuses on how we need to use these areas/resources to meet the needs of the individuals with whom we work. How can we mobilise these musical resources to meet the health and wellbeing needs of individuals within the various settings we work in? Stige suggests that there are five areas that are "musical and paramusical resources" (pp. 186-188) for "health musicking".

These areas are:

- *Arena*: The situated site or experience/situation.
- *Agenda*: The conscious or unconscious issues or themes of the participants.
- *Agents*: The residents, families, health workers, music therapists etc. who provide or take part in health musicking.
- *Activities*: Interaction and levels of engagement within the music.
- *Artefacts*: This includes songs, lyrics or instruments.

He defines "health musicking" as "the appraisal and appropriation of the health affordances of the arena, agenda, activities and artefacts of a music practice" (p. 186).

SECTION 4: EDUCATIONAL CONTEXTS (CHAPTERS 21-26)

In chapter 25 *Music-Making as a Lifelong Development and Resource for Health* (pp. 367-382), Gembris discusses how music can offer health resources and ongoing development throughout the lifespan. He focuses on how musical development shapes us, whether we are professional or amateur musicians. "Musical development can be understood as a lifelong process, which comprises time related changes in musical abilities, motivation, functions, and musical activities" (p. 367). He discusses two topics, firstly music-making as an activity in regards to lifespan development and secondly how music influences our health or how our health influences our music making.

Gembriss notes how our changing environments, development, biological or age process, cultural aspect, health and so forth, develop and shape our musical abilities and tastes. This information is relevant to music therapists as we need to be aware of which preferred music our clients listen to, and be culturally informed in regards to the role that music may play in their traditions or cultural contexts. One of the immediate ways that we connect with those we work with is through singing or playing a preferred song that is relevant to their age, generation or culture.

The author also notes how "Musical learning and changes in musical abilities, music experience and interests and activities can potentially take place at any stage in life" (p. 367). Therefore, we need to consistently be adapting our musical choice or repertoire to meet these changes.

SECTION 5: EVERYDAY USES (CHAPTERS 27-34)

Chapter 31 (pp. 477-490) discusses *Cross-Cultural Approaches to Music and Health*. Within this chapter Saarikallio discusses human behaviour and how it is situated with cultural contexts, focussing on "psychological factors and mental health" (p. 477). The way we engage or make sense of music is shaped by our background and cultural heritage. She provides insight into cognitive and ethnomusicological approaches, and the difficulties in finding "shared grounds" (p. 478) between these two approaches. Perhaps it is challenging at times to find commonalities in music therapy research and practice due to the methodological and theoretical difference in the various music therapy approaches we may use as clinicians.

REFLECTION

To summarise, this book is grounded in contemporary political relevance, providing examples into how we can connect cross culturally and break down divides through engaging in music. It also provides insight into contemporary healthcare issues, observing how health and medical care is moving towards a holistic method of treatment, and how we seem to be focusing more on prevention than cure.

MacDonald, Kreutz and Mitchell conclude that "the creative potentials of music and art are needed more than ever" (p. 10). I would recommend this book to any music therapy clinician, researcher or student working in a community, medical or educational setting. In particularly, those who are interested in exploring research into the growing field of how music affects health and provides a framework that can encourage and respond to changes in our physiological, psychological and emotional wellbeing.

BOOK REVIEW

Clinical training guide for the student music therapist (2nd ed., Polen, Shultis & Wheeler)

Reviewed by Elizabeth K. Schwartz

Independent scholar, USA
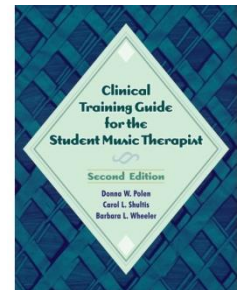
REVIEWER BIOGRAPHY
Elizabeth K. Schwartz, MA, LCAT, MT-BC is a practising music therapist in New York and an adjunct faculty member at Molloy College. She is the current chair of the Education and Training Advisory Board of the American Music Therapy Association and active in music therapy advocacy. Elizabeth writes and presents frequently on early childhood music therapy and is co-founder of Raising Harmony: Music Therapy for Young Children. [ekschwartzmtbc@gmail.com]

Learning to be a music therapist challenges the student and educator alike with working in the complexity of music as well as the complexity of human experience. Synthesising this information into an easy-to-use, accessible book, while still covering the breadth of knowledge necessary to be a competent practitioner, is a daunting task. Fortunately, three highly recognised and regarded music therapists from the United States (US) have devoted themselves to this task not once, but twice. The newly revised second edition of *Clinical Training Guide for the Student Music Therapist* is now available from Barcelona Publishers. Donna Polen, Carol Shultis and, particularly, Barbara Wheeler are familiar names to many, and among them have trained hundreds of music therapy students across several decades. Donna Polen LCAT MT-BC, lead author for this edition, is Coordinator for Music Therapy at a facility for people with developmental disabilities in New York, and an active advocate, educator, presenter and author. Carol Shultis PhD LPC MT-BC is Assistant Professor of Music Therapy at Converse College in South Carolina as well as a frequent presenter and writer. Barbara Wheeler PhD MT-BC, retired professor from Montclair State University in New Jersey and the University of Louisville in Kentucky, continues with this book to add to her extensive legacy of music therapy literature, teaching and leadership in the field. It is apparent that these three professionals are uniquely situated to know and understand how best to educate beginning music therapy students.

As a music therapy clinician/supervisor and adjunct instructor in music therapy at Molloy College in New York, I extensively used the first edition of *Clinical Training Guide for the Student Music Therapist* published in 2005. I found that the succinct writing and clear, simple organisation helped new music therapy students to begin to 'think' like a music therapist. One of the strongest benefits in both editions is the emphasis on the melding of theory and practice. In a 2006 review of the first edition

in the *Nordic Journal of Music Therapy*, Jane Edwards noted "For the early stage student, this book could act as an exemplar of why theory is not just required but also useful" (Edwards, 2006, p. 196). I could not agree more.

The overall format of both editions walks the student through the basic steps in the music therapy process including assessment, planning, organisation, implementation and documentation. The process of music therapy is then applied to the wide variety of populations that are served in music therapy. Surprisingly, I found that both graduate as well as undergraduate students appreciated this beginning text. As an educator, however, I felt it necessary to assign supplemental readings to complement the broad overview presented since actual practice requires much greater depth of knowledge, understanding, and skill than some 200 pages can cover.

The second edition follows the same general organisation and design of the first. Fresh writing and new formatting contains subtle yet discernible allusions to deeper levels of practice that I found lacking in the first edition. The second edition does away with the previous tiered assignments at the end of each chapter that divided levels of training in a manner more in line with older training models in the US (i – Observing, Participating, and Assisting; ii – Planning and Co-leading; iii – Leading). The authors discuss the importance of this change in the *Introduction*, echoing comments on the first edition from educators across the US, readers from countries using a different training model than the US, and the reality that diversity (age, prior education, prior experience, differing backgrounds) of music therapy students has significantly increased. In the second edition, the authors invite music therapy educators to use the scaffolded assignments flexibly to meet the dynamic growth of each individual student. The guided assignments in the second edition also move toward a greater focus on reflection and journaling, and rely less on learning and practising activities.

Another subtle change in the second edition is the weaving of varied contemporary theories throughout each chapter. References to neurological practice, brain research and music-centred practice (among others) are all placed within the context of the overall process of music therapy. I believe this echoes current reality where new music therapists must be prepared to work with any population in any type of practice environment. All three authors are familiar with, and probably influenced by, the writings of Kenneth Bruscia, founder of Barcelona Publishers. Bruscia, one of the most prolific contributors to music therapy literature, has advocated for a more integral approach to music therapy practice in which the therapist is less bound by adherence to a singular method (2013). This way of thinking fits well with the focus on overall process that organises the second edition of *Clinical Training Guide for the Student Music Therapist*. The book also shifts language from the first to the second edition by using music therapy-specific terms suggested in the writings of Bruscia. These include codifying music therapy experiences into four broad categories: Improvising, Re-creative, Compositional, and Receptive Experiences. This adoption of broad yet commonly accepted terms helps in making the text less reliant on models of practice and more focused on general process.

The overall change in tone of the book begins immediately in the first two introductory chapters. The authors have incorporated discussions of Bruscia's evolving definition of music therapy and provided an up-to-date overview of music therapy theories. The assignment sections ask open-ended questions that can be very helpful in sparking student introspection.

Chapter 3 is a new section that contributes a much-needed review of academic preparation, clinical training, supervision and professional and certifying organisations (AMTA and CBMT) in the

US. I am not aware of any other text where this is covered so comprehensively. While it might not be as useful outside the US, educators in other countries could create their own list of resources following the format of this chapter.

It is refreshing in the second edition to find chapter 4 referencing more literature from music therapy rather than outside disciplines in explaining the process of planning for music therapy. Although there are new mentions of the work of Abraham Maslow, the bulk of the discussion uses ideas from Bruscia that have found their way into common use. The chapter also places a greater emphasis on the importance of ethical practice and is reinforced by mention of recent formal documents on ethics from AMTA and CBMT. Once again, educators from countries outside the US could insert documents created by their own organising bodies. One detail in chapter 4 did cause me some concern, and that is comments that students will learn to notice on an 'intuitive level' or will have an 'intuitive sense' when first observing a client. As an educator, I consistently emphasise that 'intuition' in practice must be built on a strong foundation of knowledge and experience. Since the rest of the book points the student toward the benefits of analysis and study in competent practice, the authors might want to rethink or clarify their use of the term 'intuitive' in further editions.

Chapters 5 and 6 cover music therapy assessment and goal planning – two topics where the wide variety of current practice makes it challenging to balance general guidelines with population-specific details. The writing in each of these second edition chapters is happily much more decisive in presenting the view that music therapy assessment and goal writing can and should rise to unique professional and expert standards. The authors have moved from almost rationalising the need for music therapy assessments in the first edition to a definitive stance that music therapists have the knowledge and expertise within their own discipline to assess and plan. This is supported in chapter 5, *Client Assessment*, with references to a significant number of new music therapy assessment tools created since 2005 (e.g., MATADOC, IMTAP, MAA-R). The authors attempt to explain these new tools within the larger discussion of the purposes of music therapy assessment as well as domains of assessment. One concern with this chapter in the second edition is the formatting: two tools in particular (the 1993 Bruscia *General Behavior Checklist* and the 1995 Polen *Music Therapy Assessment for Adults with Developmental Disabilities*) are no longer printed on a stand-alone page and this makes it more difficult for students to print them out as templates for use in clinical placements. I was also disappointed to see that the sample of the SEMTAP assessment (p. 52) had not been revised since the first edition. There was also no mention of assessment for adolescents with psychiatric disorders or a section on assessment practices in mental health or wellness.

In the introductory paragraph of chapter 6, *Goals and Objectives*, the authors strongly state that music therapy is a focused practice with clinical purpose that is manifested in clear goals and objectives. They then suggest options as well as give examples for writing goals. These examples are helpful for beginning students but might feel limiting and prescriptive for some educators. The authors do, however, successfully strike a balance in both discussion and examples between goals that are music-centred and goals that are non-musical.

Chapter 7 combines basic but solid and useful information on session planning and implementation, much of which is the same from the first edition. There is a quick discussion on the evolving use of technology within practice with several resources listed to find further information. At the end of this chapter a few short paragraphs cover the evaluation of music therapy procedures. My

view is that this area needs to be expanded – although some of the issues of counter-transference and bias in evaluation of client responses are covered in chapter 18 on self-assessment.

Chapters 8 through 11 move into an overview of the Bruscia defined music therapy experiences of Improvising, Re-Creative, Compositional and Receptive. Each chapter is divided into two sections, with an overview according to use by population followed by a literature review for each of the categories listed (Children with Special Needs; Adolescents and Adults with Intellectual and Developmental Disabilities; Adults with Psychiatric Disorders; Older Adults with Age-Related Needs; and People in Medical Settings). The four chapters begin with a much-expanded definition and synopsis of each experience. This is a huge amount of material to present in a very brief outline and I commend the authors for giving students a wide and varied context for practice. While the music therapy literature referenced includes a significant number of current articles, it also maintains information on seminal work by earlier practitioners of music therapy such as Nordoff and Robbins. As with the first edition, I think that students appreciate the clinical examples interspersed with the literature review. Another aspect that I particularly valued was the authors' consistent emphasis on connecting music therapy experiences with client assessment and goals. As with earlier chapters, though, I would have liked to see adolescents with psychiatric disorders and mental health and wellness addressed along with the other population-specific sections.

As an educator, I found that the discussion and tables in chapter 12, *Further Considerations in Planning*, to be some of the most useful in the book. The new edition includes all the prior information and adds a much-needed section addressing developmental stages in adulthood. The stand-alone format of the tables (Stages of Development in Developmental Therapy; Levels of Music Therapy Practice; Levels of External Structure in Music Therapy; and Levels of Music Therapy Practice and Clients Appropriate for Each Level) are very helpful in organising thinking about the needs of clients across the wide variety of treatment settings. Sadly, the short section on *Music Therapy Theoretical Framework* is identical to the first edition, reflecting not the authors' limitations, but the current lack of commonly accepted music therapy theory taught in the field today.

The discussions in chapters 13 and 14 guide students more deeply into both verbal and musical interventions used in music therapy practice. The last section of chapter 13 is a new examination of the expressive elements of music that lead smoothly to the next chapter on the role of music in music therapy. Both chapters include recent sources and again rely heavily on the writings of Bruscia. The introductory paragraphs are particularly valuable in tracing the history of changing views of the role of music within music therapy practice giving a nod to *music-centred music therapy* and *health musicking*.

Individual and group work in music therapy are covered in the next two chapters, 15 and 16. The text is dense with useful references and resources. Educators will appreciate the brief listing of stages of development in both group and individual growth proposed by various practitioners. Chapter 15 also includes a new section outlining primary therapeutic factors in groups as defined by widely recognised group therapy expert Irvin Yalom.

Chapter 17 brings the music therapy process to a close through the discussion of documentation. Several measurement systems appropriate for use in different music therapy settings are reviewed and are expanded from the first edition to cover indexing in Nordoff-Robbins Music Therapy. Perhaps the most helpful portion of the section for students will be the sample progress

notes. Two examples are given that follow the much-used formats of SOAP (Subjective, Objective, Assessment, and Plan) and DAP (Data, Assessment, and Plan).

I have the pleasure to professionally know all three authors of *Clinical Training Guide for the Student Music Therapist*. The final chapter on self-assessment for the music therapist is a testament to the personal commitment each of these authors has made to practice, teach and write about music therapy in a mindful and reflexive way. They advocate for the student music therapist to follow this path through personal examination or personal therapy and include a guide on using music for self-assessment.

The second edition of *Clinical Training Guide for the Student Music Therapist,* available in both print and as an e-book, will be a useful and basic resource for the beginning music therapy student and a valuable guide to help the music therapy educator lead students in the journey to competent, ethical practice.

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BOOK REVIEW

Collaboration and assistance in music therapy practice: Roles, relationships, challenges (Strange, Odell-Miller & Richards, Eds.)
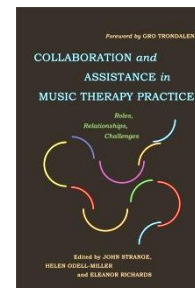
Reviewed by Margaret Broad

Barchester Healthcare, United Kingdom

REVIEWER BIOGRAPHY
Margaret Broad, BA, MSc, works with Barchester Healthcare and also as a freelance music therapist offering music therapy to support frail older people with physical disabilities and dementia. She previously worked for seven years with Nordoff Robbins Scotland with children and adults with a range of learning difficulties, communication disorders, emotional behavioural difficulties, mental health problems, and in end of life care. She has also facilitated placements for students on the MSc Music Therapy programme at Queen Margaret University, Edinburgh. [mvbroad@talktalk.net]

The presence of significant others in music therapy sessions has proven to be an ongoing topic for discussion during supervision of my own clinical practice. In examining the complexities of working alongside others, recurring and sometimes unanswered questions have arisen. In which circumstances is it helpful to have additional assistance? Do extra hands become a hindrance rather than an aid to therapeutic practice? How do we as therapists adapt our practice to meet the challenges of working collaboratively in diverse situations? Discussion with colleagues showed that I was not alone in wrestling with such thoughts. On opening this book, I experienced an immediate resonance on reading "A well trodden territory in need of a map" (p. 13), an apt title for the introductory chapter of this latest addition to the literature.

Edited by three very experienced therapists and researchers, John Strange, Helen Odell-Miller and Eleanor Richards, this book explores the role of carers, staff, assistants, students, volunteers and family members as skill sharers in music therapy sessions, and demonstrates the benefits of collaborative, integrated cross-disciplinary work in a variety of settings. Containing eighteen chapters, it is written by international authors from a clinical, narrative and/or research perspective and is intended to help practitioners and trainees in their practice.

In the Introduction, which provides a succinct summary of each chapter, Strange suggests this book should be regarded more as a "reader" than a handbook (p. 15) as it does not offer a one-size-fits-all model. It seeks to address a gap in the literature in focusing on the importance of attendees in

facilitating the developing relationship with clients and in enabling clients to gain as much as possible from their music therapy sessions. As Strange points out, there can be no "fly on the wall" as everyone present in the room will impact on the music therapy session whether as an active participant or observer (p. 14).

He then goes on in the next chapter to discuss his work with teenagers with Profound Multiple Learning Difficulties (PMLD) and the teenagers' Support for Learning Assistants (SLA), implementing an approach described as a Triadic Support of Interaction by Improvisation (TSII), which supports the client-assistant relationship through improvised music. SLAs were shown video footage of sessions in which they themselves had participated. Findings from semi-structured interviews of their responses to the video clips are discussed in relation to attachment theory. Strange identifies the need for further study and leads the reader to chapter 13 in which he explores this topic in greater detail and outlines the challenges of researching the outcomes of improvisational music therapy. From the reader's perspective, it may have been helpful in leading to a clearer understanding had these chapters been linked consecutively within the book.

Attachment theory permeates the writing of several authors in this volume. Anthi Agrotou presents her analysis of a single case study of a pioneering psychodynamic group music therapy project in Cyprus (chapter 8). Young adults with profound learning disabilities had grown up from early childhood in an isolated state institution, looked after by mainly untrained staff who had little expectation of the patients' functional and emotional abilities, and with little stimulation or emotional contact between them. This chapter traces the development of the growth of attachment bonds between carers and patients facilitated by group therapy acting as a secure base and by the therapist modelling ways of being which enabled carers to respond intuitively towards patients. Carers became primary attachment figures, rather than 'escorts', and were able to facilitate the patients' evolving ability for self-expression, creativity and intimacy as "buried skills saw the light of day" (p. 165). Agrotou describes this as an "apprenticeship model" (p. 166) with carers developing into effective responsive auxiliary therapists. For me this is a very powerful and moving chapter, clearly written with musical examples highlighting the journey of the therapeutic process. I was left with an overwhelming desire to see video footage of this work, a feeling which was indeed reinforced in the subsequent chapter when Tessa Watson (p. 181) refers to Agrotou's (1999) moving video.

Watson describes an approach developed over many years working with people with PMLD using a music therapy and sensory interaction group involving pre-composed and improvised music, physiotherapy exercises, intensive interaction and Soundbeam technology. In this chapter she specifically works with carers to develop their own working practice. Sessions are led by two therapists who model facilitative relating and provide an environment where emotions may be contained, offering a creative space for care staff to observe and reflect about clients in new ways. She places particular emphasis on the importance of waiting and silence to facilitate client processing and response. Watson highlights a gap in the literature of the importance of touch when working with people with profound multiple learning difficulties. Touch is present in all early attachment relationships yet some places of work have 'no touch' policies. She discusses the parallel process for therapists and staff in dealing with their own feelings surrounding the sometimes painful realities of their work and poses the question of how work and feelings interact with policy and strategic thinking in the current healthcare climate.

During her MSc studies at Queen Margaret University, Hannah Munro investigated the experience of five music therapists from different training backgrounds with diverse clinical experience who had worked with staff in sessions (chapter 2). She identifies benefits and challenges of team working and concludes that successful collaborative working is most likely to be achieved when staff understand that music therapy is client-led and when they themselves feel valued and have an understanding of their role. Munro provides guidelines for good practice covering the management of the therapist-assistant relationship including what is expected of both therapist and assistant. These guidelines may be of particular interest for trainee therapists.

The experiences of trainees working on placement with assistants is investigated in the next chapter by Catherine Warner, clinical supervisor and music therapy educator. She presents retrospective accounts from three practising music therapists which form part of a larger ongoing narrative inquiry research study. Warner highlights the variety of placement models and approaches offered on different music therapy training programmes in the UK. She considers how the presence and intervention of others may affect trainees' work and the development of their identity as a therapist. The insights in this chapter may be of particular interest for supervisors and educators as well as trainee therapists.

Helen Odell-Miller describes the role of co-therapists and assistants who are non-music therapists in adult mental health and dementia groups (chapter 5) and considers the dynamics arising from their inclusion. She highlights a gap in the literature with regard to assistants acting as a dynamic force to enable the development of trust and interaction in music therapy which might not otherwise be possible.

Jorg Fachner discusses in chapter 10 the traditional role of co-therapist in the sense of the Nordoff and Robbins partnership. He notes this chapter differs from the rest of the book in that a Nordoff Robbins co-therapist is likely to be a trained music therapist who only meets the client in the context of music therapy. Although this chapter is written from the therapist's point of view, he also identifies a gap in the literature regarding the perspective from the co-therapy angle and examines the scope of the co-therapy role and the relational quality of therapy. He says the intuitive relationship which evolves between therapist and co-therapist can enable the co-therapist to become the therapist's "third arm" and the "catalyst" of art between therapist and client (p. 198). He notes cultural differences in approach in leading and following within the therapeutic process, evident amongst Nordoff Robbins therapists in the USA and Germany.

Music therapist Ruth Melhuish describes a qualitative study undertaken jointly with dance movement therapist Catherine Beuzeboc in a nursing home in London for residents with moderate to advanced dementia (chapter 6). The study was initiated in response to an arts therapies service review identifying a need to develop and evaluate ongoing service provision at the home. The intention of the authors was not to compare and contrast their respective art forms but to focus on common aims of facilitating emotional expression and developing relationships with others. Music therapy and dance movement therapy sessions were conducted separately and supported by care staff. Findings from staff interviews identify the impact of this experience on staff attitudes and approaches to their own practice. Melhuish highlights many issues relevant to contemporary approaches in dementia care. Insights into the therapists' own perspectives of working in this collaborative venture were not addressed in this chapter but would have been of interest.

Ming Hung Su, head music therapist with the charity Methodist Homes Association continues the theme (chapter 7) of supporting residents and caregivers involved in the field of dementia care. He suggests that by equipping caregivers with additional skills and knowledge they can play a significant role in prolonging the effects of music therapy beyond the session on a day-to-day and moment-by-moment basis. Using the qualitative results from caregiver interviews, he examines how music therapy might be embedded in daily care and highlights the global challenge and major therapeutic target of managing neuropsychiatric symptoms in dementia care.

In chapter 11 Strange, Fearn and O'Connor describe an approach named 'Music and Attuned Movement Therapy' developed while working with children with profound neurological damage in partnership with other professionals or family members who take the role of 'movement facilitator' in offering multi-modal communication. Clear musical transcriptions illumine the interaction between musical input and the physical responses of the child. Mutual respect and a shared agenda developed between therapists and nursery nurses with post-session debriefing forms a crucial part of the therapy. A very welcome inclusion by the authors is the perspectives of the health professionals supporting this intervention. The physiotherapist describes the therapist's music as attuning by following rather than leading which strengthened her own focus on the child. From the occupational therapist's perspective, musical structure contributed to the child's active engagement. Parents were also supported to carry therapeutic strategies into the home environment.

The theme of collaborative working continues in the subsequent chapter, co-authored by Strange and Lyn Weekes who was head physiotherapist at a large UK NHS hospital for people with learning disabilities in the 1970s. Weekes worked collaboratively with the late Tony Wigram in developing an approach called 'Music and Movement', a hybrid intervention between physiotherapy and music therapy with a key role for hands-on assistants whose sensitive use of touch to facilitate movement lies at the core of this model. Lyn and Tony worked mainly with groups of adult clients at risk of developing fixed deformities. The aims of this approach were ultimately those of physiotherapy to maintain and extend flexibility and range of movement. The means, however, were modifications of physio- and music-therapeutic strategies.

Sarah Hadley of Oxleas Music Therapy Service outlines the nature and origins of 'Interactive Music Making' in a children's community music service. Interactive Music Makers are trained to offer a developmentally-based service to children with less complex difficulties than those offered traditional music therapy. She discusses the collaborative roles of transient practitioners (music therapists) and constant practitioners (parents, teachers and others with whom the child has ongoing contact). Hadley developed a Music Therapy Home Programme by skill sharing with parents to foster secure attachment bonds between parent and child facilitated through music making.

Pornpan Kaenampornpan also offers guidance (chapter 4) on the involvement of parents and family members in music therapy sessions as well as in the home environment. Her doctoral work at a special education centre in Thailand focuses on the experience of family members participating in sessions with their children with special needs. Kaenampornpan draws attention to cultural differences which may impact on the dynamic of the therapeutic process. She concludes that the participation of family members played a central role in encouraging their child to engage in sessions and also helped the development of a partnership which enabled the therapist to gain a deeper understanding of the children's needs.

Changing attitudes to inclusion within the education system are discussed in chapter 15 by Motoko Hayata and John Strange. They describe clinical work undertaken in a mainstream school using 'inclusion' groups. Children with special educational needs were supported not only by staff but also mainstream pupils who acted as helpers. Using case studies the authors examine the benefits to disabled and non-disabled pupils and staff, and the intricacies of the helping relationships. A most interesting read particularly for therapists working in the education sector.

Tone Leinebo, paediatric nurse and music therapist, and music therapy professor Trygve Aasgaard present their work in a paediatric hospital department. Working with medical staff, parents and siblings in a variety of musical activities they demonstrate the ability of music to build bridges between people and to foster positive experiences for patients and families.

In the penultimate chapter of this volume entitled 'Someone else in the room; welcome or unwelcome?' Eleanor Richards focuses on the therapist's attachment perspective with specific focus on attachment to the patient, to a preferred approach and to theory. In part she reflects on attachment perspectives offered in earlier chapters. Using a supervision case study example, she considers how shared music making may help foster more secure attachments for all those involved in the therapeutic encounter.

The editors reiterate the aim of this book in the concluding chapter; namely, to demonstrate the important contribution that assistants and collaborators can make to music therapy. Some useful suggestions are offered in relation to student training courses such as devoting a module specifically to collaborative working with assistants and other professionals as well as planning placements in settings where collaborative working is likely. The need is identified for formal research and raising the profile of collaborative working via social media, journal articles and conference presentations.

This stimulating, informative volume contains a richly diverse source of material that must surely become essential reading on music therapy training courses. As well as addressing a gap in the literature, it points the reader towards a wealth of sources for further contemplation. If the well-trodden territory is in need of a map then this book is a signpost towards exploration of new pathways as we share the collaborative journey.
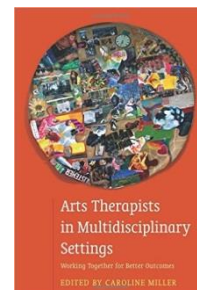
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BOOK REVIEW

Arts therapists in multidisciplinary settings: Working together for better outcomes (Miller, Ed.)

Reviewed by Jane Burns

Queen Margaret University, United Kingdom

REVIEWER BIOGRAPHY

Jane Burns, PhD, Lecturer in Art Psychotherapy at Queen Margaret University, Edinburgh. Areas of research interest include arts therapy work with the older person, life transitions and working with children and adolescents on the autistic spectrum. Working alongside collaborative partners *With Kids*, Jane has recently developed the first MSc Play Therapy programme at Queen Margaret University. [jburns@qmu.ac.uk]

I pondered upon the title of this book before actually opening the front cover. The term 'multidisciplinary' it could be argued has become, in everyday parlance, what we might call a 'loaded' word for many health professions (Burns, 2009; Tsiris et al., 2016). I was reminded of my early days negotiating differences in practice with my non-arts therapy trained colleagues. As the lone arts therapist working in various day and residential services for older clients, I left work sometimes head-in-hands, despairing if we would ever find shared pathways or common ground. On other days I left work with a spring in my step as I realised a piece of professional collaboration had succeeded.

Similar issues are discussed in this book which, from start to finish, provides a fascinating insight into different multidisciplinary team (MDT) approaches. The text is written from the perspectives of New Zealand and Australian trained arts therapists and explores through discussion and vignette case example how they negotiate their way with their colleagues.

The book begins with the editor, Miller, giving an overview of the advantages and disadvantages of MDT working. She discusses the clear need for arts therapists to have a strong evidence base from which to give voice to their work. Miller suggests arts therapists, not already actively engaged in research, might wish to access their local university for guidance on database searching and research strategies in order to develop their own evidence-based practice.

Much of the rest of the book is a series of case examples in which the writers (all arts therapists) provide very honest and revealing accounts pertaining to the complexities of working as an arts therapist. The lens through which individual therapists discuss their work is not fixed on their respective art, music, drama or dance discipline (although writing in the case chapters does illustrate

clearly the modality) but refreshingly there is an assumption that the arts therapists share a core set of principles and values. The real focus of the book is the professional relationships arts therapists have with colleagues from different health professions.

In chapter three, for example, Raymond's discussion of inter-professional differences illustrates the cavern that can exist between professions. Working with a young boy with autistic spectrum disorder who initially was resistant to participating in the group, Raymond – an arts therapist – was pleased to see that after a few sessions her client began to work independently with little prompting for at least half the session. This, however, was interpreted more negatively by the child's behaviourally-orientated case worker. She felt that Raymond was feeding into the child's avoidant behaviour during times when he was not participating in the group activity. Raymond realised that she needed to do some groundwork in terms of speaking with co-workers and finding out their perspectives. What she learnt was that they employed a variety of other strategies such as mindfulness, visual and behavioural techniques, some of which she integrated into her own practice. She noticed, after some time, that other colleagues became interested in her perspective on their work. Perhaps what this points to is the need for more transparent communication and a willingness to listen? Not always easy in today's climate when therapists and their colleagues are often working to such time pressures in often under-staffed settings!

Raymond offers some useful tips for new arts therapists joining multi-professional teams. This is largely focused on the importance of getting 'out there' and mixing with colleagues and telling them what we do and listen to what they do. She reminds us not to underestimate how little colleagues might know about the arts therapies.

Gordon-Flower's writing in chapter four makes an interesting point about working multi-modally within a multidisciplinary team. She refutes Moon's (2006) concern that multi-modal working adds a layer of confusion to teams getting to grips with what arts therapists actually do. Gordon-Flower points to the fact that she is trained to work across modalities and that her approach has been evaluated by her 5-point Star Assessment tool (Gordon-Flower, 2014). Multi-modality working is perhaps an area that audiences in the UK, where I am based, might be less familiar with as the majority of training is still largely discipline-specific. In New Zealand, however, there is only a dedicated music therapy programme while training in art, dance and dramatherapy is combined. In relation to training readers may be interested to visit the 2016 special issue of *Approaches* edited by Karkou (2016).

In Chapter five, Spragg discusses her music therapy work within a special education setting. She highlights how MDT working together can develop professional standards and best practice. She points to the need for a clear focus on a set of narrower rather than context-specific goals when working as part of an MDT so team members know each other's role.

Working outside the parameters of the care setting, Halliday's chapter offers a fascinating discussion of her work with Fiona and her family. As Fiona's Motor Neurone Disease progresses Halliday's art therapy work with Fiona moves from the hospice to her home. The writer talks movingly about the delicate fragile situation which the therapist as outsider must negotiate when working in the home with the potential family member in close proximity. Having worked with Fiona until her death, Halliday describes the process of offering bereavement art therapy to the family. This starts with Fiona's husband and daughters reflecting upon Fiona's images (which she had shared

with them) and then moving on to create their own image by choosing a letter from her name as a starting point. Finally, the letters are brought together into a shared image containing her full name. Although this example is not MDT-specific, it does illustrate the diverse nature of the work of arts therapists.

In chapter 12, Fletcher offers insight into working as a music therapist in a remote and rural location in New Zealand. In her discussion of working with Melissa, a traumatised 15-year-old Maori girl, we learn how a team of counsellors, social workers and Maori specialist mental health officers worked alongside the music therapist to provide an intervention for Melissa. Ultimately, music therapy provided the key to unlocking Melissa and helping her to move on but only, as Fletcher acknowledges, because there was an MDT supporting her work. The therapist reflects that many layers make up the MDT approach and if one layer is missing then a successful outcome is less assured.

This review offers just a snapshot from this rich collection of thought-provoking essays and case examples exploring MDT approaches. Importantly, this book illustrates innovative ways in which arts therapists adopt and adapt practice while staying true to their theoretical principles.
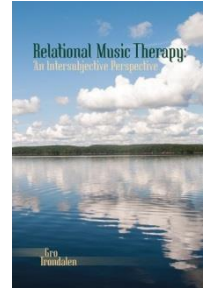
I look forward to a second edition!

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BOOK REVIEW

Relational music therapy: An intersubjective perspective (Trondalen)

Reviewed by Morva Croxson

Massey University, New Zealand

REVIEWER BIOGRAPHY

Morva Croxson is President Emeritus, Life Member, and past Chairperson of Music Therapy New Zealand. She was Senior Lecturer in Music at Massey University College of Education before training in music therapy at the Guildhall School of Music and Drama, followed by a Master of Philosophy through Massey University with a thesis focused on music therapy with children who have cerebral palsy. She has wide experience in music performance, music education and music therapy, and has presented and authored a broad range of music therapy topics. Morva has served on several national arts advisory boards, including chairing the Music Panel for the Queen Elizabeth II Arts Council. Morva was Chancellor of Massey University from 1997-2002, and was awarded Doctor of Literature, Honoris Causa, from that institution in 2003. Although retired from a broad-based music therapy career, Morva remains actively involved with the Master of Music Therapy programme at the New Zealand School of Music, as examiner and Advisory Panel member. She has maintained a wide range of national, local educational and community links, and is an active advocate for the arts, especially music. [M.O.Croxson@massey.ac.nz]

I read this book twice to determine how best to approach this review; the language used required some attunement and analysis. This provided a rewarding experience overall, both ratifying some held beliefs that came with different descriptors, and introducing subtle new insights into the less articulated music therapy territory which Trondalen terms 'Relational Music Therapy'. This is a well-presented overview of the components and background of relational music therapy, encapsulating in some detail the views of others. There are 280 references, particularly from Scandinavian researchers and writers, with 132 sources of published and non-published material from this geographic area. There are some personal reflections from the author, and I would have liked more of these. It is mainly a theoretical book though several chapters include cameos from practice-based experience and here there is personal expansion which is refreshing.

The sub-title 'An Intersubjective Perspective' gives a lead to the thrust towards the reality and variability of music therapy content in situations where dialogue in sound is occurring between therapist and client. At all times Trondalen manages to remind us of the unspoken subtle nuances that appear and that have to be recognised as important components. These nuances cannot be rigidly categorised; every client comes with a different background and every session contains unplanned pathways and sudden illuminations. The music making itself makes the interchange a powerful mix of sound production, movement, non-verbal thinking and feeling.

What was the genesis of this book? It was inspired by a 1996 lecture from Daniel Stern at a meeting of the Nordic Network for Music Therapy Research where Stern's topic was 'How do people change in psychotherapy through non-verbal means?'. Stern identified what he termed first "hot present moments", then in later writing (Stern, 1998) "moments of meeting". Stern's work has been a strong influence for Trondalen; she quotes throughout the book from 11 of his publications, all with valuable co-related ideas.

From my background of varied practice and consultancies in music therapy with limited research experience, initially I found the Introduction and first two chapters headed 'The Relational Turn' and 'Intersubjectivity' rather daunting semantically. Chapters nine and ten, 'The Music Therapy Relationship' and 'The Relational Music Therapist', were at last familiar; they had resonance with personal experience. On return to the start of the book, however, the rather dense and intense prose of the initial chapters suddenly became more understandable and accessible. So persist and re-read!

Trondalen identifies five models of music therapy practice quoting Bruscia (2014) and Wheeler (2012) who postulate that models of music therapy practice are still developing. The inference always is that a broader perspective has resulted which reflects the social, cultural and political environment of the modern world. She states (p. 4) that "interpretative phenomenology" (Smith, Flowers & Larkin, 2009) is a useful basis for an intersubjective perspective on relational music therapy. Furthermore, she reiterates that her book focuses on modern developmentally informed theory; it does this in a somewhat careful way. Chapter three, 'Development as a Dialogical Continuum' as you might expect relies on Stern (1985, 2000) primarily, and I liked the phrase "the narrative self" (p. 29) as a description of literal or symbolic personal experiences. The modern world loves storytelling as an educative and communicative tool in one form or another, and it is an easy fit with the music therapy process too.

A simple interpretation would be that chapter four covers 'how to proceed or do things'. Then chapters five, 'Vitality', and six, 'Synchronization and Affect Attunement', talk about the sense of being alive and the nature of interplay interactions. Chapter seven picks up the affect thread, taking it first into the world of a child, then particularly exampling receptive music therapy and Guided Imagery and Music (GIM) for adults. Following this, a broad approach to personal growth and human development is presented in chapter eight and, as mentioned before, the subsequent two chapters, nine and ten, add a music therapy emphasis on participation. The ninth is a full and rich chapter giving the flavour of varied thinking of well-known researchers who explored cultural and social factors.

I notice that there is very little reference to neurological research anywhere in the book. Nor is the term 'Community Music Therapy' much included – perhaps that nomenclature has become too limiting. Chapter ten emphasises the person-centred approach; in music therapy practice the music therapist will create a space where trust develops, providing a safe working environment for the client. The therapist is also encouraged to be more intuitive.

The final two chapters seem to be more of an appendage than an overview of the important points Trondalen makes. Comments pertaining to power and responsibility, however, are valuable as is the inclusion of ethics as being central to practice. There is an epilogue which has condensed thoughts about basic patterns of relating, life interpretation and existential being, balancing the individual need for autonomy with the human need to find relationships.

Trondalen offers words and ideas that bring the impact and momentum of music therapy to the fore. She asks us to look into ourselves as practising music therapists and give more credence to the powerful momentum of the wonderful sound identity that is music. She also reminds us that there is increasingly convincing research into music therapy practice that is exploring material with a qualitative aura. It is refreshing to have these ideas presented in such detail although one has to work hard to absorb all the shades of interpretation she presents around the term 'relational music therapy'. One cannot stress too often that a wide range of music and non-music sources of research, thought and opinion have undoubtedly influenced the flavour of Trondalen's writing. Various music therapy training and research pathways in music therapy have been mandated by the prescriptive requirements of learning institutions and funding sources, and early music therapy writing had to adapt to accommodate those bureaucratic lifelines. The content, however, adds a more reflective, in-depth flavour to one's memories of music therapy practice, especially relating to improvisation and GIM.
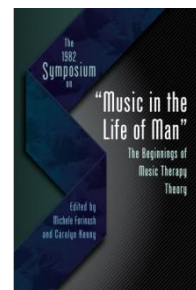
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BOOK REVIEW

The 1982 symposium on 'Music in the life of man': The beginnings of music therapy theory (Forinash & Kenny, Eds.)

Reviewed by Denise Grocke

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REVIEWER BIOGRAPHY
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Over many years I have heard anecdotal reflections on the symposium held in 1982 on 'Music in the Life of Man'. I have listened to reflections by those who were participants and those who were student observers, and all accounts have left me with the impression that this was truly a watershed moment in the evolution of music therapy theory and practice.

Thirty-three participants came from the four corners of the world to be part of this event. They represented music therapists (two-thirds) and others from adjacent fields (ethnomusicology, music psychology, music performance [voice and piano] and composers).

This slim volume was published in 2015, some 33 years after the event. What stands out about the publication is the layering of information and reflection of those involved coming from multiple perspectives. It is a study of the lived experience of the event, and as such illustrates a phenomenological perspective that is deep in meaning and understanding.

The editors, Michelle Forinash and Carolyn Kenny, begin the book with an outline of their involvement in the symposium; Carolyn a part-time professor at that time who was a participant, and Michelle a graduate assistant within the Masters programme at New York University (NYU).

The symposium was the brainchild of Professor Barbara Hesser, who had attended a previous gathering at Herdecke, Germany, in 1978. Carolyn reflects "little did I know that during those five days I would meet my professional tribe – a community of scholars" (p. 4), and Michelle recalled "my excitement and at times fear about meeting the leaders in music therapy" (p. 6).

Barbara Hesser garnered financial support for the project from the Musician's Emergency Fund and NYU. She wrote that the focus of the meeting was

> [...] to bring people of varied disciplines together with music therapists who all share a
> common interest in the musical experience as it refers to man and his life (his

education, growth and health). […] a transdisciplinary symposium to explore the essence of our profession: how music affects the body, mind and spirit of man. (p. 8)

The structure of the book covers the significance of the gathering (chapter 1), notes taken after each person's presentation, the small group discussions, and the public presentations on the final day. Finally, there are reflections from the participants sometime after the symposium.

Each person had written a paper that was distributed to all 31 participants prior to the meeting. Although these papers were never made public, the student scribes took copious notes on the presentations, dutifully typing up the summaries at the end of the day on electric typewriters! In addition, participants wrote comments and reflections on cards at the end of each day.

The findings from the small group discussions focused on:

1. Illness and wellness in music experience
2. Encounters the self in music experience
3. Experience of time and rhythm in music therapy, and
4. Appropriate/acceptable approaches to studying music experience.

I was struck by the use of "wellness" considered by group 1. In their report on the final day they defined it then as "an optimal state of wholeness in the physical, emotional, mental and spiritual self" (p. 51). Group 4 put forward a diversified approach to research music therapy including case studies, correlational analysis and experimental models; phenomenology, semiotic and introspective approaches as well as meta-analyses (p. 62), an accurate prediction of where research methods would eventually evolve.

Other delights in this book are the references to paper copies of plane tickets being sent by snail mail to participants, typewriters "breaking down" and the use of "overheads" for the public presentations. An endearing quality of this volume can be found in the historical photographs of the pioneers of music therapy, circa 1982.

The book captures a moment in music therapy history that allows us to live the debates of the time and to reflect on the solid grounding this meeting gave to the subsequent development of music therapy theory and practice. It is a gem, and highly recommended to music therapists around the world.

BOOK REVIEW

The music of being: Music therapy, Winnicott and the school of object relations (Levinge)

Reviewed by Giulia Fedrigo

Independent scholar, Italy
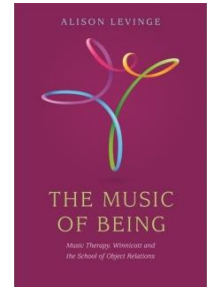
Title: The music of being: Music therapy, Winnicott and the school of object relations **Author:** Alison Levinge
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REVIEWER BIOGRAPHY
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Communication is defined as the ability people have to use symbols to create meaning within and across channels, media, cultures and contexts (Miller, 2016). Words are symbols we use to represent something else, and when they are combined they form the most prevalent symbol system: language. Through words we are able to communicate with other people, to share our knowledge and imagination, and to shape our external and internal world. But what if a person is left without communication, no words or symbols to express their inner feeling and thoughts? Or what if their language is so distant from the symbols we use to share meaning that it becomes difficult for others to understand? Being able to create and use symbols to communicate is one of the most momentous and mysterious aspects of humanness (Langer, 2009) yet it is also one of the biggest challenges that children and adults who come to music therapy often face in their everyday life.

In her book *The Music of Being: Music Therapy, Winnicott and the School of Object Relations,* Alison Levinge explores the ideas of paediatrician and psychoanalyst Donald Winnicott as key to uncovering the world of meaning concealed behind the exchanges with our patients, independent of the symbol that is used, whether communication is through music, language or action (and reaction).

Levinge shares pictures of particularly intense moments of her own experiences of clinical work with children and adults who are, on many different levels, impaired in their ability to communicate efficiently through the means of language. Conscious and unconscious processes that take place in the therapeutic relationship are then investigated through the lens of a psychoanalytic approach, in which the theory of object relations takes centre stage.

Indeed, as highlighted by Levinge, it is not enough for us as therapists to "create a space in which (we) can be with (our patients) to help (them) to find some relief and transformational quality to their

life", but rather what is necessary is "to find the means by which some sense of what has happened (in the music therapy space) can be made" (p. 8).

In chapter one the author gives a picture of the analytical family in which the theory of object relations was developed, providing the reader with the historical background and ideas that most influenced this school of thought. Beginning with Freud, we follow the transformation of the understanding of human development through the eyes of Klein and Fairbain until we reach the ideas of this family's most recent influential theorists: Winnicott and Bowlby.

The second chapter describes the figure of Winnicott under two particular aspects of his life: firstly, the central role of the feminine figure in the theorist's early life and its influence on his thinking on the mother-child relationship; secondly, and just as importantly, the role that creativity played in his life through the forms of music and the musicality of his words.

Particular emphasis is given by Levinge to the liveliness, freedom and musicality of Winnicott's language, and the strong relationship to music both in Winnicott's private life and in the way he used words to express his ideas, which could be spontaneous, playful and highly attuned. Those characteristics lead Levinge "to see a striking connection between how Winnicott used the language of words and [her] own employment of the medium of music as a therapeutic tool" (p. 29). Throughout the book the author remarks on this connection between language, play and music, making it easy to adapt Winnicott's theories of the mother-child relationship to the relationship the author has, as a music-mother, with her patients.

Music takes the central role in the third chapter, where its characteristics, its connection with language and its role in therapy are discussed. Levinge uses a quote by the musician Daniel Barenboim to describe the difficulty of explaining in words what happens in a musical relationship, which is seen as a "musical experience communicated by non-verbal means [that has] the power to impact upon one's whole being" (p. 43). Music therapists and their clients enter into communication with each other but also with the different parts of our selves. The nature and quality of music can be viewed as "a special kind of language" (p. 47) which, in a therapeutic setting, can allow our patients to connect with some part of themselves that have perhaps been ignored or protected and have not been easily reachable with the language of words.

From the start of life, we are exposed to music in many different ways. Our relationship with music and with the musical elements of life begins before we are born and continually shapes our experience, creating relations with the world. Levinge here highlights how this early experience is at the base of the formation of the first relationships in life. We make meaning of our experience with communication that is initially not made of words, but is made of musical elements that form a language and a bridge between our inner word and other relational words.

Chapter four is devoted to some of Winnicott's most important concepts and again frames her discourse between historical backgrounds and reflection on her work as a music therapist. Levinge not only explains the holding concept but also its development from Bowlby's "objective approach" (p. 57) and the importance Winnicott placed on the internal world of the child.

Chapter five deals with the concept of play and the observations of an infant in a set situation. I found this chapter particularly interesting for my practice as I can observe some of my own experiences reflected in those recalled by the author. Play can be a lens through which we understand our client's inner world, from being a "simple and enjoyable dramatization" to a "denial of the inner

world life" (p. 80). In reflecting upon the mother-infant relationship, Winnicott views a direct connection to what also "occurs in the analytic consulting room between an analyst and a patient" (p. 86). This can be considered similar to those connections that music therapists also make with their clients through play. This concept is fully introduced later in chapter eight where play theory is linked to musical play. Levinge suggests that when we improvise as a music therapist we create a musical relationship and a "holding framework in which the moment to moment musical connection can evolve" (p. 125).

Chapters six and seven focus respectively on the concept of transitional objects and transitional phenomena, and on the concepts of aggression and hate. Transitional objects and phenomena are one of the most well-known contributions of Winnicott's thinking on infant development: in his theory he sees a third space between the inner, subjective and merged world and the objective, separated and external world a child is immersed in, a space in "which transitional objects and phenomena are brought in order to aid the process of keeping inner and outer reality 'separated yet interrelated' (Winnicott, 2008, p. 3)" (p. 90). Within these chapters, Levinge alternates between the description of these concepts and her notes from therapy sessions, and shares not only stories of success but also, and perhaps most poignantly, her concerns and questions about what was going on for a particular client. These reflections highlight beautifully the purpose of the book, which facilitates the reader in the process of understanding and applying these theories to his/her own experience as they are so sensitively reported by the author.

Chapter nine is dedicated to the concept of self, its dependence on the experiences we receive in our external world and on how we manage and elaborate them. The role of the mother is again at the centre of this chapter and it is described in relation to the formation of the infant's self. The emotional and relational environment in which we grow up shapes the way we develop and who we will become, and it is strictly dependent "upon both what and how we experience the external world, followed by what these experiences come to mean" (p. 134). Levinge moves through the chapter with various examples to describe the primary role of the mother in making sense of the world for the child, not only with emotional availability but also the ability to connect and attune to the child's needs. Levinge reflects on the therapy setting where our object as therapists is to "find ways of creating spaces with our patients where we are able to think about and reflect upon their experience" (p. 138). It is our role to provide the patients the environment in which they can express their self and in which "our shared music (can be) filled with intense feeling created not through imitation" but through attunement.

Further important considerations for therapy are discussed in chapter ten. Transference and countertransference are introduced to the reader as two potent tools in psychoanalysis that therapists can use. This chapter requires the reader to have some basic knowledge in order to fully understand the explanations given by the author. However, chapter eleven collects Levinge's final reflections on the impact of Winnicott's theories on her own clinical work. Levinge concludes the book with a reflection that can be considered the point of arrival of an intense journey through the world of Winnicott in which she approaches the question of how we can create a potential space in which play, and consequently change, can occur.

In order to lead the reader through a thorough understanding of the concepts, Levinge discusses them in the context of therapeutic practice, a thread which is ongoing throughout the book.

I found the topics covered in the book very interesting and appealing. This book provides some excellent material for reflections on our clinical work as music therapists, but also provides a basis for understanding the psychoanalytic theory of Winnicott, its origin and influences, and its applicability to the field of music therapy. The book offers different clinical examples of how the theory of object relations and the creative thought of Winnicott can inform our understanding of the wordless musical moments we share with clients. It is therefore helpful for all music therapists and music therapy students. As a music therapist who often uses improvisation in working with children, I found this correlation highlighted by the author to be interesting and significant, and perhaps one of the reasons why Winnicott's theories are particularly useful.

Coming from the Italian context where Winnicott's theories are surely known to those who study psychology, but not necessarily to those who study music therapy, I was delighted to have the opportunity to engage with some of these concepts from psychoanalysis (such as the transitional objects, holding, transference and countertransference), which were less familiar to me. With this book, Levinge offers the opportunity to locate these theories within our specific therapeutic context, however the author does assume some prior knowledge of key theories and I did not always find it easy to navigate for that reason.

In conclusion, this is an important contribution to the literature and one that deepens the relationship between the analytic work of Winnicott and the field of music therapy. It requires some familiarity with the theoretical framework and concepts addressed. However, I found the language chosen by the author and her open and honest stance on her experience and inner world related to the therapy context to be very helpful in explaining theory, and the book will certainly offer stimulus to deepen the understanding of Winnicott and how his theories apply to the practice of music therapy.

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CONFERENCE REPORT

Music in the psychoanalytic ear: Thinking, listening and playing

Nicola Dunbar

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Music in the psychoanalytic ear: Thinking, listening and playing
Institute of Musical Research, University of London
19 May 2018, London, UK

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Nicola Dunbar trained as a music therapist in 2001 and has since worked with adults and elderly in adult mental health services and more recently with children. She has a particular interest in working with under-fives and their carers. [nicoladunbar@libero.it]

The *Music in the Psychoanalytic Ear: Thinking, Listening and Playing* conference took place at the Institute of Musical Research at the University of London on Saturday 19th May 2018. It was organised by Rachel Darnley-Smith, music therapist and music therapy lecturer at the University of Roehampton, and Samuel Wilson, a musicologist from the Guildhall School of Music and Drama and London Contemporary Dance School. Their aim was to address the need for interdisciplinary dialogue between music, music therapy, and psychoanalysis: "Musicologists, music therapists, and psychoanalysts have talked about music, *but rarely do they speak to one another* about music" (Darnley-Smith & Wilson, 2018, p. 2).

The programme was organised in four sections with someone from each of the three disciplines presenting in each section: Communities and Identities; Technique and Method; Sounds, Listening and Performance; finally ending with a roundtable entitled *'What are we listening to? What do we hear?'*.

Listening as a music therapist about to embark on a child psychotherapy training, I was intrigued as to how the room might begin to dialogue. There are long-established links between music therapy and psychoanalysis, and many music therapists have gone on to additional training in counselling or psychotherapy. Music therapy and musicology connect through 'performance' and the music of music therapy and its aesthetic content. In linking musicology and psychoanalysis some presenters related their studies to the Lacanian school of thought, whilst one performer/musicologist, Max Wong, described his exploration of Bach's life and relationships and, in particular, the significant losses in his life at the time when writing his solo violin partitas, in order to support his interpretation of the music. In this way the worlds of music, feelings, emotions, behaviours, habits, words, self-expression, and humanity were all overlapping as we looked on from our different perspectives. Below I summarise what I found striking from this most thought-provoking day conference.

Kate Brown, a psychoanalytic psychotherapist, presented *'Psychoanalysis Beyond the Spoken Word: Musical Attachments in Therapeutic Communities'*. She began with a description of a therapeutic community that she had worked in before her psychotherapy training. Here the quality of her listening (she was already a trained musician) was paramount in enabling her to begin to engage with those in the community. Her ability to tune in to the silence, to quietly introduce her cassette player and tapes, and then to nurture what grew out of that shared listening and reactions to her music was the start of building a real community amongst these deeply traumatised individuals. She made reference to authors describing the musicality of early interactions (e.g. Stern, 1985) and attachment theory, as well as trauma theorist Judith Herman (1992), who argues that reconnection with one's community is integral to recovery from trauma. In this way, Brown described developing significant relationships through listening to the 'music' of each individual, their own voices, sounds and cries, and how they related to her and her music, and then to one another in the community. The music of the community then, with all its harmonies and discords, was most revealing of the qualities of those underlying human relationships and interactions, and also provided an important tool with which to engage the clients.

The importance of the music made between client and music therapist, how it might fit in a musical 'genre' or not, what 'approach' it embodies, and a warning not to lose sight of the client amidst these issues was unpicked by music therapist and jazz saxophonist Luke Annesley in *'Two Kinds of Music Therapy'*. Drawing on his own clinical work, he illustrated the conflicts of interest present for the musician that is the music therapist, how (s)he listens to the co-created improvised music of the session, its aesthetic qualities, and how the client's voice/role is considered within that. Annesley highlighted the importance of supervision for therapists: how his supervisor heard (in one case example) his client's musical voice quite differently to him. In this case, Annesley was offering an experience replicating the dynamic that played out in that child's home rather than challenging it or offering an alternative. This stood as a warning not to get too drawn into the music purely for its aesthetic at the expense of those that we work for. It made me wonder about who trains as what and why? Do musicians who are not able to survive on performance alone train to be therapists in order to earn a living with the focus still on their own development as performers? What are the implications for their clients if that is the case? Writing as a musician for whom performance was not an option for making a living, is my music 'up to scratch' or not? And for whom? How does the 'good-enough' music therapist, like Winnicott's 'good enough mother', play? We would hope that these considerations are part of analysing and listening to the work, as well as thinking about it together with supervisors or colleagues. There is always the question of how aesthetic considerations and focus on the client and their relationship with the therapist overlap, especially as many of our clients are less musically able than ourselves. Such questions require the capacity to look honestly at oneself in supervision and beyond, just as Annesley suggests. In this way our perceptions of ourselves as therapists (and performers?) and what we can offer, evolve, develop, expand and change over time.

In the section on technique and method, transformative experiences through Guided Imagery and Music (GIM) and Jung's theory of synchronicity were described in a case study by music therapist Catherine O'Leary. Then musicologist Rebecca Day grappled with how Lacan's ideas of subjectivity could provide a means of understanding music's role in the re-presentation of consciousness through analysing a short extract of a Beethoven piano sonata. She argued that in this light "music does not

only *represent* our inner-life, but that it is equivalent to the processes that are foundational to it" (Day, in Darnley-Smith & Wilson, 2018, p. 8).

This presentation was followed by psychoanalytic psychotherapist Anastasios Gaitanidis discussing the links between music and words, the music and affect of words, their rhythm and tonality, pitch and timbre. He referenced Thomas Ogden's paper *'The Music of What Happens'* (1999) and how "both poetry/music and certain analytic sessions seem to generate powerful resonances and cacophonies of sound and meaning" (Gaitanidis, in Darnley-Smith & Wilson, 2018, pp. 8-9), with an emphasis on considering the musical affect rather than the usual referencing of psychoanalytic concepts and theories.

A roundtable at the end of the day allowed psychoanalytic psychotherapist Rosemary Rizq to reflect on how her extensive musical education as part of her childhood and upbringing Influenced her music-listening and, later in her professional life, the way in which she listened to and heard words. This was contrasted by the experience of Ann Sloboda, a gifted musician who then chose to train as a music therapist and work with words and music and psychoanalytic theories in her practice. What came across as most important to me was the key focus on listening to the words and physicality of a person and how that changes as the session unfolds – the musicality of how we are together inter-subjectively. This kind of listening is probably a basic skill and principle for many music therapists. However, what was striking for me is how important this is also in psychotherapy, and thus the psychoanalytic 'framework' of this listening, too. The discipline of music therapy has much to offer that of psychoanalysis, in particular in the area of non-verbal attunement. This gives me great encouragement as I embark on my own psychotherapy training, confirming just how much the listening and observational skills of the music therapist can bring to the discipline of working in words.

This thoughtful conference was an opportunity to reflect on the macro- and micro-capacities of music to sound out and reflect whole communities and their wellbeing; the opposite, detailed interactions between client and therapist; as well as much in between (not elaborated in this conference report, but examples include Canadian national identity and the band *'The Tragically Hip'*, as well as dream-work in GIM.). All the subtleties of music and words were acknowledged as important tools for understanding and helping ourselves and the people we work with. The more opportunity there is to acknowledge our shared as well as complementary skills between disciplines the better. In this vein, I would welcome another opportunity to get together and think more about these processes; for myself, next time with a particular focus on work with children and families.

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CONFERENCE REPORT

Collaborative approaches to music and wellbeing research

Steven Lyons
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CONFERENCE DETAILS

Collaborative approaches to music and wellbeing research
Society for Education and Music Psychology Research (SEMPRE)
University of Leeds
9-10 November 2018, Leeds, UK

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Steven Lyons is a PhD student exploring the value of arts therapies for older people with dementia. He is also a practicing music therapist with experience of working in schools, community centres and NHS hospitals. [nevetslyons@outlook.com]

INTRODUCTION

This two-day conference was an opportunity for academics, practitioners, musicians and students to come together and discuss the relationship between musical engagement and wellbeing. In their opening remarks conference directors Freya Bailes and Karen Burland, both music psychologists, provided some background information about their journey into this area of research. As academics at the University of Leeds, they were approached by the North Yorkshire Music Therapy Trust, who had received funding to explore the value of music therapy in Yorkshire communities. The initial purpose of this collaborative project was to distinguish the unique attributes of music therapy as compared to other forms of musical activity. However, as a result of mapping the range of interactive music making opportunities across the region, new connections between music therapists and community arts providers were identified. It was hoped that this conference would continue to explore the potential benefits arising from a collaborative approach to mapping therapeutic needs and provisions as well as fostering opportunities to share knowledge and practice.

DAY ONE

The conference was a relatively small gathering but, as well as researchers from local universities, there were delegates from London, Croatia and even Australia. How the arts contribute to our health and wellbeing is a diverse topic that has gained increased recognition since the All-Party Parliamentary Group on Arts, Health and Wellbeing Inquiry Report (2017). The University of Leeds had brochures on

display advertising their new MA in Music and Wellbeing, and there were other academics present from York and Sheffield developing courses in this area. As a music therapist, I was slightly apprehensive about being one of a few practitioners present. However, at registration I spoke with a psychologist who shared his understanding of the conflicting views and expectations that can arise between research and practice, and I was impressed by his conviction that this area of research needs more interdisciplinary collaboration.

The sessions on this first day were divided into social enterprise, inclusive design, theories and models, and communities. The opening presentation was by Simon Glenister, director of Noise Solution, a one-to-one music mentoring program (see www.noisesolution.org). Simon described his Masters research project using the Warwick-Edinburgh Mental Well-being Scale (WEMWBS) to measure changes for young people in challenging circumstances over a ten-week period. The impetus for the research came from Simon's work with community arts organisations who were unsure how to measure their work. This sounded like a familiar struggle, but the intervention itself appeared very new: pairing vulnerable youngsters with music producers who then mentor them in the music making process. The journey into the studio was captured and then the highlights from each session could be shared on a purpose-built social media platform. Simon believes that the social media network is a crucial aspect of the intervention to help confirm the young person being good at something. The quantitative results presented showed a significant effect in the wellbeing of participants, although I think myself and others in the audience were also hoping to hear some of the finished recordings as meaningful arts-based evidence.

The presentations on inclusive design included a three-year collaboration between the University of Leeds and NHS hospitals to develop hearing aids to facilitate musical engagement for people with hearing loss. Alinka Greasley reflected on the benefits of academics working alongside practicing audiologists to gather and interpret audiometric data to understand how different profiles of hearing loss may affect musical experiences. After this, William Longden, a researcher at London Metropolitan University, presented his practice-based research exploring the production of bespoke musical instruments. He used case studies to illustrate an approach to co-designing instruments with severely impaired and marginalised people to promote social inclusion and participation. Some of the instruments were truly unique and beautifully made. More details about William's work and pictures of the instruments can be found via his charity's website: www.joyofsound.org

Later presentations challenged existing theories concerning arts engagement, with Urszula Tymoszuk providing an epidemiological perspective. Joel Swaine presented an interesting psychological model of music and emotion using video examples of Diane Austin's vocal psychotherapy to suggest how emotional states can be regulated and transformed through singing. There was also an interesting historical talk from Helen English about how music-making can be a world-building resource for migrant communities, helping to forge new connections but also connect back to past lives and places. The first day ended with a session entitled *Collaborative Conversations,* where people were invited to meet with others who shared common research interests.

DAY TWO

The second day began with the keynote from Katie Overy about music workshops with individuals living with severe dementia. The study involved a five-year collaboration between NHS Lothian and the Scottish Chamber Orchestra's outreach programme, culminating in a pilot trial to establish parameters for a future randomised controlled trial. There is an increasing scientific interest in the benefits that music can bring to individuals with dementia, but experimental research is still relatively scarce, as shown in the recent Cochrane review in this area (Van der Steen et al., 2017). The aims of this pilot study were to compare interactive versus passive music listening, identify rates of eligibility, recruitment and retention for participants on a dementia ward, and assess the intervention fidelity. The study used a between-group design with single blind allocation with a nested qualitative component (interviews with health professionals and musicians involved). The intervention involved eight weeks of live tailored music, and the outcome measure was the Cohen Mansfield Agitation Inventory. The results showed that there was no clear statistical effect, however attendance was a significant factor: of the seven participants only a few people attended all of the sessions (some only two or three times). Also, many unexpected issues came up, such as difficulties getting participants in the room with musicians, and not having enough chairs on the ward.

Despite the difficulties encountered, Overy supports the medical paradigm and randomised controlled trials as the best way of validating musical experience. As an accomplished researcher, it was interesting to hear her give such an honest account of the challenges that arose during this interdisciplinary project. One of her presentation slides highlighted the huge web of connections and collaborations necessary for the project to take place. As principle investigator, she initially placed herself at the centre of the map but acknowledged that perhaps the local care team or even the patient should take the central role. It was significant that after five years they are now considering another pilot to refine the protocol.

The other sessions on the second day focused on children and music, and Dawn Rose presented her recently published case study (Rose, Jones Bartoli & Heaton, 2018) showing how learning an instrument can benefit a child with learning and behavioural problems. This was followed by a session on musicians' wellbeing, with presentations exploring the effects of mindfulness on musicians (Anne-Marie Czajkowski), the role of leisure activities in the wellbeing of musicians (Nellinne Ranaweera), and the wellbeing effects derived from playing in brass bands (Victoria Williamson and Michael Bonshor). The last session focused on musical interventions, where Rizo Veloso described the use of carers' perspectives and semi-structured interviews to shed light on why music-based interventions might be effective for people with dementia. I also presented my own research exploring a collaborative music therapy and dance movement therapy group for older adults with dementia living in the community. This study involved developing a treatment manual based on a systematic review of current evidence (Lyons, Karkou, Roe, Meekums & Richards, 2018) and data collected included quantitative, qualitative and arts-based information.

The day finished with a panel-led discussion (led by Freya Bailes, Laura Festa, Katie Overy, Simon Procter and Karen Burland; see Photograph 1) that presented an opportunity to reflect on the conference and also to think ahead to the future. Some themes arising from discussion included the need to distinguish between wellbeing and everyday life, and whether music is always a good thing for

health. Social prescribing was mentioned, an initiative that provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and wellbeing for patients. Social prescribing extends music and arts to sports and films, and it was debated whether music is exclusively beneficial. Simon Procter, Director of Music Services for Nordoff Robbins, provided a useful sociological perspective, emphasising how the situational context helps determine the benefits of what music can offer. Music having social value was discussed, as was the importance of putting the patient (rather than the investigator) at the centre of the research. The nature of interdisciplinary work, and one's willingness to admit ignorance in a number of areas, was described as a necessity of working in this field. The panel also reflected on the difficulties of designing research that appeals to numerous stakeholders and audiences, some of whom have quite specific interests. There emerged a consensus that the focus now should be on like-minded people forging new alliances. Future collaborations between researchers experienced with funding bids and practitioners with experience of patient needs, or even the patients themselves, would be desirable.

Photograph 1: Panel discussion (From left: Freya Bailes, Laura Festa, Katie Overy, Simon Procter, Karen Burland)

SUMMARY

This conference was a great opportunity to discuss the multi-faceted benefits of musical engagement, and how it can have a positive impact on wellbeing throughout the lifespan. It was useful to hear about emerging policies from the field of arts and health, such as social prescribing, but there remained a real passion from a diverse range of people to share evidence of how music presents unique possibilities to touch lives in deep and meaningful ways. An exciting prospect for the future was the launch of a new alliance between Nordoff Robbins and the University of Leeds. *Music for Healthy Lives* is a new research and practice network committed to providing further evidence on how music contributes to healthy lives, to promote and connect music practitioners to healthcare providers, and to increase cooperation and collaboration between the members of the network. For more information please see the new website https://musicforhealthylives.org

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CONFERENCE REPORT

The 21ˢᵗ ISME Special Music Education and Music Therapy Commission pre-conference seminar *'Music across the lifespan: The role of special music education and music therapy'*

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Brandon Meeks is from Charlotte, North Carolina in the United States. He is a 2018 graduate of Florida State University where he received a Master of Music Education and is currently pursuing a Doctoral Degree in Music Education from Florida State University. While at FSU, Mr. Meeks has conducted research in teacher training and studies conducting with the university bands. Meeks is also a National Board-Certified Teacher. [bmm16e@my.fsu.edu] **Victoria Warnet** is currently pursuing her PhD in Music Education at Florida State University, where she received her BME in 2012, and her Master's in Music Education in 2018. While at FSU, her research interests have included jazz band, teacher training, and music for students with special needs. Prior to returning to graduate school, she was the Director of Bands at Tavares Middle School and the Associate Director at Tavares High School in Tavares, FL. [vmw08@my.fsu.edu]

The Special Music Education and Music Therapy Commission pre-conference seminar of the International Society for Music Education (ISME) was held in Salzburg, Austria at the Mozarteum University and Orff Institute on 12-14 July 2018. The Special Music Education and Music Therapy Commission is one of eight commissions associated with ISME, and it was established to further continue the development of special music education and music therapy in an effort to highlight the role of music in human life. Commissioners for the conference included commission chair, Melita Belgrave, along with, Michelle Hairston, Markku Kaikkonen, Giorgos Tsiris, Kimberly VanWeelden, and Wei-Chun Wang. The overall focus of the three-day conference was to bring awareness of new ideas and research that pertained to the special music education and/or music therapy professions. Specific

visions and goals set by the conference leaders consisted of advocating for students in need of special support, sharing international perspectives on current research, enhancing the quality of life for all children and adults with special educational needs and other health conditions, and improving the professional training of practitioners working in special education and music therapy (see VanWeelden, Tsiris & Belgrave, 2018).

The conference began on Thursday 12th July with the opening session at the Mozarteum University. The goals and visions of the conference were presented, as well as introductions by the commission chairs and site hosts. The stimulating goals for the conference, coupled with the welcoming nature of the hosts and general excitement of the attendees set the tone for the dynamic and inspirational conference that lay ahead. The highlight of the opening session was a performance by Vollgas Connected (Photograph 1). Vollgas Connected is an inclusive rock band style group from Germany. The following brief description of the group was provided in the conference program:

> The Music School Fürth's unique Project in Germany "Berufung Musiker" (Profession Musician) where young people with intellectual disabilities have the chance of an apprenticeship as musicians has been tremendously successful. The band "Vollgas," has become one of the most wanted bands in Germany since its foundation in the Year 2009. Amongst other triumphs they rocked the Bavarian Parliament, the Bavarian State Chancellery, the Federal Congress of the Music Schools (VdM) and they even played for the German Parliament in Berlin. (ISME, 2018, p. 4)

Vollgas Connected consisted of musicians playing saxophones, trumpets, guitars, bass guitars, auxiliary percussionists, vocalists, a piano player, and an accordion player. The group performed

Photograph 1: Vollgas Connected performing at the opening session

various hit songs that everyone in the audience was able to connect to. One of the highlights of the Vollgas Connected performance was watching the performers bond with one another and seeing how much they enjoyed playing their instruments together. By the end of their performance, the entire

audience was on their feet clapping and singing along. Many people mentioned that seeing this group perform inspired them to look into starting a similar group back in their home towns. The Vollgas Connected group served as the perfect model for emulating the goals of the conference while getting everyone enthusiastic and motivated to learn.

The remainder of the first day consisted of presentations. The schedule was designed so that conference attendees listened to three 20-minute presentations. These presentations centered around topics that were relevant to both music educators and music therapists. For example, the presentation *Music Education for All* by Shirley Winner and Alon Ram was about the development and implementation of a nationwide curriculum for special music education, while Liza Lee and Han-Ju Ho presented a case study on the development of a child with disabilities using a holistic music educational approach. It was interesting to see presentations from all over the world. Despite the diversity of practices presented, it seemed that the goal of bringing music to all people and enabling them to experience it irrespective of their abilities and disabilities was a common denominator across cultural contexts.

The types of presentations also varied, ranging from research-focused to more experiential and participatory presentations. Regardless of the presentation type and focus, delegates were supportive and welcoming to new ideas and research in the field. As participants in an international conference for the first time, this aspect of the conference was enlightening. Instead of getting caught up in issues that pertain to our home country, we were able to step outside of our comfort zone, take a look at the global picture of the field, and develop a critical yet supportive stance.

Toward the end of the first day, there was also a poster session. Attendees were given the opportunity to see various research and practitioner related posters, and speak with the presenters. Examples of poster session titles inlcuded *It's my Time: Older Adults' Motivations for Joining an Intergenerational Rock Band; Supporting Social Development in Students in Preschool through Music-Making: Teaching The Teahcers; Grooming the Next Generation of Piano Teachers; Music Therapy Intervention to Meet Parents' Needs in the NICU: A Pilot Study; Developing A Music Program for Adults with Developmental and/or Physical Disabilities; and Interactive Sequential Pattern Analysis for Children With Down Syndrome.* Even though the posters were from many countries all around the world, we recognised some commonalities in terms of the research and practices being conducted. Through speaking with many of the researchers and practitioners who created the

Photograph 2: Outside of the Orff Institute (From left: Brandon Meeks, Kimberly VanWeelden, Victoria Warnet, and Lori Gooding)

posters, we were able to take away new concepts and research ideas which we hope to apply back in our own practice settings.

After a full day of presentations and performances, there was a group dinner planned at Stigelkeller. On the way to dinner, we were able to walk through Salzburg and experience some of the rich historical background that the city had to offer. We walked through the beautiful Mirabell Palace and Gardens which was right next door to the Mozarteum University. Right around the corner, we were also able to make a stop at the residence of Wolfgang Amadeus Mozart for a quick photo opportunity. Dinner was held at an elegant family owned restaurant which was close to the beautiful and historic Hohensalzburg Fortress and had a beautiful view of the entire city of Salzburg. Dinner provided many opportunities for fellowship and networking amongst conference attendees and their families.

On Friday 13th July, the conference was held at the Orff Institute in Salzburg. The conference schedule was divided into tracks so that delegates could attend sessions and presentations based on their interest or field of study. There were four tracks: Teaching/Pedagogy, Special Needs/Teaching, Music Education for All Ages, and Music Therapy. Sessions in each track varied from research presentations to hands-on demonstrations, and audience participation. Examples of teacher education sessions were *Music Teachers' Knowledge of Special Education Terminology, Inclusive Piano Studios*, and a presentation on *Enriching Music Lives: Lessons Learned from Teacher Surveys on Inclusion* by Judith Jellison – a world research leader in music education and music therapy from the US. Having read and cited so much of her research, it was inspiring for us to see Jellison speak and to meet her in person. Similar to the schedule on Thursday, three 20-minute sessions were presented in each track.

The closing session included a performance by Die Kunterbunten 14er, which is an inclusive band ensemble at the Orff Institute (Photograph 3). Similar to the opening session performance, this group did not disappoint. They had many instruments with adaptations which allowed all of the band members to contribute and participate. The performances at this conference reminded us how much

Photograph 3: Die Kunterbunten 14er performing at the closing session

joy can come from music and why we should make it possible for everyone to participate. At the close of this conference, we named the new ISME Commissioners (2018-2020): Giorgos Tsiris (chair) (UK), Kimberly VanWeelden (chair elect) (USA), Matthew Breaden (Australia), Melissa Bremmer (The Netherlands), Erik Esterbauer (Austria), Michelle Hairston (USA), and Weichun Wang (Taiwan). As we were leaving the Orff Institute, the hosts invited us all to sign the guest book of the Institute; this is the same book that was once signed by Carl Orff himself.

On Saturday 14th July, there was an excursion: the Sound of Music Bus Tour around Salzburg (Photograph 4). During the tour, the bus was filled with people singing their favourite songs from the movie as we travelled from stop to stop. This experience allowed conference participants to see some

gorgeous scenic views around Salzburg, including the famous Untersberg mountain which the von Trapp family allegedly used to escape from the Nazis to Switzerland. Toward the end of the tour, the bus stopped in the small town of Mondsee where we were able to see the famous church where the wedding of Maria and Baron von Trapp was filmed in the movie. Here we were also given a little bit of time to explore the town and took that opportunity to grab a local staple, apple strudel, which did not disappoint. Four hours later, after beautiful photos, many delicious apple strudels, and many verses of *Do Re Mi,* the tour and the conference came to a close with another walk through the gorgeous Mirabell Gardens. We all parted ways, leaving with many new research and teaching ideas, as well as the many new friends we all made at the conference.

Photograph 4: Views from the Sound of Music tour

The next ISME Commission pre-conference seminar will take place in the summer of 2020 in Finland. We look forward to seeing you there.

REFERENCES

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